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Companion documents

NQPHN Mental Health Planning Framework 2016
NQPHN Needs Assessment 2016
NQPHN Mental Health and Suicide Prevention Needs Assessment 2016
NQPHN Alcohol and Other Drugs Needs Assessment 2016
Improving Mental Health Services in the Primary Health Care Sector – NQPHN Overview (A3 document) 2017
NQPHN Mental Health and Suicide Prevention Regional Plan 2017
NQPHN Alcohol and Other Drugs Regional Plan 2017

Alcohol and Other Drugs Regional Needs Assessment 2017

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Northern Queensland Primary Health Network respectfully acknowledges the Traditional and Historical Owners, past and present, within the lands in which we work.
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Introduction

Primary Health Networks (PHNs) were established in 2015 by the Australian Government with the aim of increasing the efficiency and effectiveness of medical services for people (particularly those at risk of poor health outcomes) and improving coordination of care to ensure people receive the right care, in the right place, at the right time.

One of the key roles of Northern Queensland Primary Health Network (NQPHN) is to lead the planning and commissioning of regional Alcohol and Other Drugs (AOD) services, with a focus on coordination, to ensure better outcomes for individuals and their families.

This document contains information obtained in the initial alcohol and other drugs needs assessment conducted in 2016. Ongoing AOD planning will be informed by this locally undertaken needs assessment which has encompassed consultations with our key partners and communities.

The NQPHN has been tasked with the planning and commissioning of drug and alcohol treatment services to reduce the risks of harm associated with drugs and alcohol in the community. There is a stated focus on methamphetamine use and planning and commissioning for Aboriginal and Torres Strait Islander specific services. The regional approach to its alcohol and other drugs planning will take into account of the following key factors:

- the spectrum of needs within the population and effective responses
- the range of settings through which services are delivered
- the diverse social contexts of northern Queensland
- considerations that may vary according to user characteristics (e.g. gender, race, particular substance, comorbidity with mental disorders, forensic considerations etc).

Drawing from this process and the collective regional knowledge about what works in our region, NQPHN will develop a Regional Alcohol and Other Drugs Plan. The plan will be grounded in and guided by local contextual considerations and in partnership with key stakeholders such as state and national peak bodies, local hospital networks, non-government organisations, and other specialised service providers including Aboriginal and Torres Strait Islander organisations and general practices.

National alcohol and other drugs reform

The Commonwealth Government’s AOD policy directions and priorities are articulated within the following key reports and policy documents:

- Australian Government’s Response to the National Ice Taskforce’s Final Report 2015
- The National Ice Action Strategy 2015
- The National Drug Strategy 2011
- Queensland Alcohol and Other Drugs Treatment Service Delivery Framework, March 2015
- The alcohol and other drug service planning guidance materials developed by the Australian Government for the Primary Health Networks (2016)

The Commonwealth Department of Health has developed specific guidance materials for the PHNs in their commissioning of AOD treatment services. The intention for the AOD funding is that it will:

- increase the service delivery capacity of the drug and alcohol treatment sector through the commissioning of additional methamphetamine, alcohol and other drug treatment services
- improve the effectiveness of drug and alcohol treatment services, by increasing coordination between various sectors and improving sector efficiency.
The funding will provide additional methamphetamine, alcohol and other drug treatment services for clients, their families, and the community through primary care and specialist services.

The following types of treatments and services are in scope for funding by NQPHN:

- **early intervention** targeting less problematic drug use, including brief intervention counseling
- **withdrawal management** with pathways to post-acute withdrawal support and relapse prevention
- **residential rehabilitation** with pathways to post-acute withdrawal support and relapse prevention
- **day stay rehabilitation** and other intensive non-residential programmes
- **post treatment support and relapse prevention**
- **case management, care planning, and coordination**
- **supporting the workforce** undertaking these service types through activities which promote joined up assessment processes and referral pathways and support continuous quality improvement, evidence based treatment and service integration.

**Methodology**

The Alcohol and Other Drugs Regional Needs Assessment is a working document, that evolves as new and more relevant information becomes available, through both data as well as ongoing community consultations and feedback. The needs assessment is not an exhaustive list of all services and consumer needs, rather, it is an essential process in identifying key areas specific to our community.

This document has been developed in line with Commonwealth guidelines using primary data sources obtained from Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), the Commonwealth Department of Health, in addition to specific data provided by Queensland Health and other local health service providers. Furthermore, we include summaries of workshops obtained during stakeholder consultation, and specific consumer consultation and feedback.

Forty five workshops facilitated by local Mental Health, Alcohol and Other Drugs, and Aboriginal and Torres Strait Islander health experts were conducted in a wide range of locations across the NQPHN region in 2016. Over 268 people participated in these workshops. In addition to the face to face consultations, an online survey was conducted with 197 individuals completing the mental health survey, and 95 completing the alcohol and other drugs survey.

Additional workshops were held across the region with key stakeholders, including consumers and carers, to feedback the information obtained in the needs assessment and as a group to prioritise ongoing activity. The NQPHN team is actively building on these early consultation structures and engagement across the region. In December 2016 and January 2017, co-design workshops were held in six locations across the region to progress from the needs assessment into the co-design phase and priorities for inclusion in the Regional Alcohol and Other Drugs Plan to be finalised in early 2017.
Outcomes of the health needs analysis
[1] Identified need: Socio-economic status of the region’s population

Key issue

The socio-economic status provides useful insight into the broader determinants of health within a population. Overall, the population in the Northern Queensland Primary Health Network (NQPHN) region suffers greater disadvantage than that of Queensland as a whole.

Affordable and accessible health services in rural and remote areas, where there is a high proportion of people who are low income earners, will be critical to delivering improved health outcomes in the NQPHN region.

Lower educational achievement is strongly associated with higher levels of dependence on government benefits. In addition to indicators of poverty, these socio-economic indicators identify a group of very vulnerable people within the population who are often trapped in a downward spiralling poverty cycle.

The NQPHN region is comprised of some very remote areas with a diverse range of health needs. For health consumers, remoteness generally translates to reduced access to health services. While for providers, remoteness is associated with difficulty in attracting and retaining workforce. Remoteness and distance can also increase the cost of fresh fruit and vegetables, which can impact on the population’s health and wellbeing.

Low rates of completed schooling in Torres and Cape and other remote areas indicate that there may be reduced health literacy in these areas.

Persons with disabilities are identified as one of the most vulnerable groups within a society. Within the NQPHN region, a large proportion of those who report a disability were Indigenous Australians. Persons with disabilities and those who care for them require additional support and equality of access to primary health services. Early detection of a disability also enables better management and outcomes for these persons, often with extensive allied health professional involvement.

Just under 50% of the population fall in the first two quintiles of the index, representing those that are most disadvantaged.

Torres and Cape region: 73% of the population are within the most disadvantaged quintile, with only Weipa having people in quintile 4 and 5 (least disadvantaged).

 Cairns and Hinterland region: 1/3 of the population are in the most disadvantaged quintile.

There are pockets of extreme disadvantage across the region: 12 LGAs (of 31) in the NQPHN region > with 100% of the population in the most disadvantaged quintile (9 within the Torres and Cape region)

This often correlates to areas that are highly remote.
Description of evidence

Household income in the NQPHN region approximately follows that for Queensland more broadly, however there are pockets of the region that have significantly lower incomes than the state average. 43 per cent of the Torres Strait and Cape York population fall in the lowest income bracket (<$400/week or $20,800/year), compared to 32 per cent across the NQPHN region (or 35 per cent in Queensland). In Aurukun, Wujal Wujal, Yarrabah, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Pormpuraaw, the Torres Strait Islands and Palm Island, over 50 per cent of the population falls in the lowest income bracket.

Overall, the NQPHN region’s labour force participation rate is on par with Queensland, with its unemployment rate of 5.4 per cent lower than that of Queensland (6.1 per cent). Noticeable variations from this average are:

- Mackay HHS region has the lowest unemployment rate (3.6 per cent) and the highest labour force participation rate
- Torres and Cape region has the highest unemployment rate (8.7 per cent) and lowest labour force participation rate of 53 per cent
- Yarrabah, Aurukun, Hope Vale, Napranum and Palm Island LGAs have unemployment rates over 20 per cent, as well as noticeably lower labour force participation rates indicating a significantly lower proportion of working population.

In almost all categories, the NQPHN region shows a higher proportion of people on government benefits than the State and National averages. Although most indicators are approximately one per cent higher than the State average, some LGA are far above the average.

Over 30 per cent of the population aged 16 to 64 in Aurukun, Wujal Wujal and Yarrabah receive an unemployment benefit. These LGAs also have higher proportions of people receiving unemployment benefits for more than six months (Aurukun 25.6 per cent, Wujal Wujal 37.1 per cent and Yarrabah 36.3 per cent). Poverty is more likely to affect young children than any other group. The number of low income, welfare-dependent families (with children) is higher in some LGAs such as Northern Peninsula Area, Torres, and Torres Strait Island, where the proportion of families in this category is over 30 per cent. Over 40 per cent of children in Cook, Northern Peninsula Area, Torres and Wujal Wujal areas live in low income, welfare-dependent families.

On average people in the NQPHN region have a slightly higher percentage of dwellings without a registered motor vehicle. In some small remote LGAs this percentage is much higher, though a vehicle may not be necessary to access local infrastructure and services.

Overcrowding is highly associated with increased disease carriage rates, in particular childhood ear and diarrhoeal diseases. These both have long-term sequelae as ear disease leads to hearing loss and deafness, and long-term diarrhoeal diseases are associated with malnutrition, failure to thrive, and stunting in infants.1,2

2,263 people across the NQPHN region did not go to school, with a further 62,000 (13 per cent) who did not complete year 10. Torres and Cape has the lowest proportion of people that completed year 12 (33.9 per cent against 46.6 per cent for Queensland) and the highest proportion that did not finish year 10 (16.7 per cent, against 11.7 per cent for Queensland).

In Croydon, Etheridge, Wujal Wujal, Yarrabah, Aurukun, Hope Vale, Kowanyama, Napranum, Torres Strait Island, Charters Towers, Flinders and Hinchinbrook, 20 per cent or more did not finish year 10. In Mapoon, Pormpuraaw and Palm Island, 30 per cent or more did not complete year 10.

In 2015, there were 26,548 persons in the NQPHN region (3.9 per cent) reported as ‘has need for assistance with core activities’. Of these, 2,389 were Indigenous Australian persons (approximately nine percent). Those with disabilities represent three per cent of the entire Indigenous Australian population of the NQPHN region.

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[ 2 ] Identified need: Cultural determinants

Key issue

A ‘social and cultural determinants’ approach recognises that there are many drivers of ill-health that lie outside the direct responsibility of the health sector and which therefore require a collaborative, inter-sectoral approach.

Description of evidence

For Aboriginal and Torres Strait Islander peoples there is an increasing body of evidence demonstrating that protection and promotion of traditional knowledge, family, culture, and kinship contribute to community cohesion and personal resilience. Current studies show that strong cultural links and practices improve outcomes across the social determinants of health.¹

[ 3 ] Identified need: Social impacts and determinants of drug use

Key issue

Harmful AOD use causes significant harm to individuals, families, and communities. However, it is important that harmful AOD use in any community is not considered in isolation, as there are many contributing factors that often vary with the type of drug. For example, harmful AOD use is linked with poorer health outcomes, including increased risk of disease and injury, and shortened life expectancy, which then lead to increased costs to the health and hospital systems, and also the deterioration of family and community. Harmful AOD use can also adversely affect a person's education, employment, health, and involvement with the criminal justice system, which can have a whole-of-life and, in many cases, intergenerational impact.⁴

As identified in the needs assessment, drug use can have a significant impact on disadvantaged groups and lead to intergenerational patterns of disadvantage. There is strong evidence of an association between social determinants—such as unemployment, homelessness, poverty, and family breakdown, and drug use. Socio-economic status has been associated with drug related harms such as fetal alcohol syndrome, alcohol and other drug disorders, hospital admissions due to diagnoses related to alcoholism, lung cancer, drug overdoses, and alcohol-related assault.⁵
Managers of facilities reported that they sometimes felt the services were used as a ‘dumping ground’ for people with mental health issues and those being released from prison or on parole. They stated that there is no specific funding available to facilitate meaningful transition from mental health and corrective facilities for people with AOD issues. All managers thought that there is a need for ‘step-out’ facilities for people to go when they are in transition to rehabilitation facilities.

Description of evidence

Overall, alcohol misuse is responsible for 3.2 per cent of the total burden of disease and injury in Australia.

The NQPHN region has an average unemployment rate of 5.4 per cent. This ranges from 3.6 per cent in the Mackay area to 8.7 per cent in the Torres Strait and Cape York area. Within the region there are LGAs with significantly higher rates, including Yarrabah at 61.7 per cent.

Thirty two per cent of the NQPHN population are in low income brackets ($0-399/week), whereas the figure in some remote communities is far higher, such as Wujal Wujal at 75 per cent.

In 2015–16 there was an increase in drug related offences in the Queensland Police Service regions that align with the NQPHN catchment: eight per cent increase in Northern region and six per cent in Central region. (QPS Annual Statistical Review 2015–16).

There is strong evidence to suggest that our population is subject to increased rates of domestic and family violence, family breakdown and child neglect as a result of high rates of substance misuse.

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4 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019
Identified need: Health disparities for Aboriginal and Torres Strait Islander people related to alcohol and other drugs use

Key issue

Aboriginal and Torres Strait Islander issues around AOD misuse are complex and multi-causal, and addressing these issues requires a comprehensive approach that considers social determinants, prevention, culturally safe care and treatment and support to clients, families and communities.\(^6\)

The needs assessment highlighted the correlation of suicide and self-harm with excessive substance use, specifically alcohol. Studies show that suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females. Intentional injury is not the most common cause of alcohol-related death in non-Aboriginal population.\(^7\)

Consultations through the NQPHN communities identified need at a community level for a holistic integrated approach to AOD treatment when the same staff treat both disorders in the same setting. This was particularly highlighted in communities that had Aboriginal Community Controlled Health Organisations (ACCHO). Other feedback around needs included:

- more education for schools, youth groups needed for prevention and early intervention, including building resilience and coping strategies
- culturally appropriate detoxification and residential rehabilitation services to effectively meet the needs of young people from rural and remote locations
- opportunities for Aboriginal and Torres Strait Islander communities and services to develop their own AOD local area plans and strategies.
Description of evidence

Surveys of AOD use are of varying quality and consistency and always underestimate actual consumption, however, they indicate that levels of harmful use among Aboriginal and Torres Strait Islander Australians are about twice those in the non-Indigenous population.\(^8\)

At a national level:
- Illicit drugs are estimated to cause 3.4 per cent of the burden of disease and 2.8 per cent of deaths, compared to 2.0 per cent and 1.3 per cent among the non-Indigenous population nationally.
- Aboriginal and/or Torres Strait Islander males are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.2 and 6.2 times those of non-Indigenous males.
- Aboriginal and/or Torres Strait Islander females are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.3 and 33.0 times greater compared to non-Indigenous females (including injuries related to assault).
- Deaths from various alcohol-related causes are 5 to 19 times greater than among non-Indigenous Australians.
- Aboriginal Community Controlled Health Organisation’s national report, as part of the online services report, identified amphetamines as a common substance-use issue which increased from 45 per cent in 2013–14 to 70 per cent in 2014–15.
- In 2014–15, 57 organisations providing non-residential, follow up and after care services reported around 19,900 clients. This was similar to 2013–14 (around 20,100).
- Most non-residential and after care clients were Indigenous (81 per cent). More than half of all Indigenous clients (57 per cent) were male and 39 per cent were female. Forty-three per cent of all Indigenous clients were aged 19 to 35 and a similar proportion (43 per cent), were aged 36 and over. Clients aged 18 and under made up a smaller proportion (14 per cent) of Indigenous clients.\(^10\)

Data for the FNQ population indicates that Aboriginal and Torres Strait Islander people are over-represented in the criminal justice and child protection systems, with 55.9 per cent of children in out-of-home care and with 71 per cent of prisoners at Lotus Glen prison being of Aboriginal and Torres Strait Islander background.\(^9\)

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\(^{8}\) Queensland Alcohol and Other Drugs Treatment Service Delivery Framework (March 2015)

\(^{7}\) Dudgeon, P., Milroy, H. and Walker, R. (2014) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice

\(^{8}\) Gray, D.and Wilkes, E. (2010) Reducing alcohol and other drug related harm, Resource sheet no. 3 produced for the Closing the Gap Clearinghouse

\(^{9}\) National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019

\(^{10}\) Australian Institute of Health and Welfare (2015) Aboriginal and Torres Strait Islander health organisations Online Services Report—key results 2014-15

\(^{11}\) Cairns Alliance of Social Services: Position Paper 2016
[5] Identified need: Insufficient access to residential rehabilitation facilities particularly for young people

Key issue

Within the NQPHN region there are eight AOD rehabilitation specific facilities located at Cairns, Mackay, Townsville, Palm Island, Yarrabah, Mareeba, and Cooktown. All facilities accept both female and male clients over the age of eighteen years and five accept both Aboriginal and Torres Strait Islander and non-Indigenous clients. The Cooktown facility has a focus on services for families, not individuals, and their intake is from Cape York reform communities or from people who have a family connection to Cape York Aboriginal and Torres Strait Islander communities.

Young people were identified as a group that requires specialised commitment and skills. All facilities stated that they do not accept people under the age of 18 and the only youth rehab facilities are located in south-east Queensland—thereby further isolating young people. There are a number of organisations who provide programs to engage with young people, however they only operate in business hours, posing issues for after-hours care and support.

In terms of service footprint, all facilities indicated that they accept clients from any geographical area (including interstate).

Description of evidence

Consultations across the region with communities, service providers, and peak organisations identified the need for increased capacity in residential rehabilitation services including peer support, onsite primary health care services including general practice, and after-care support services.

Admission waiting times in all facilities within the NQPHN region are between 2–4 weeks, however at certain times it can be up to six weeks.

No residential rehabilitation facility specifically for young people within the region although the Cooktown facility accepts families.

At a national level, the top four principal drugs of concern most clients received treatment in a residential facility for were alcohol (63 per cent of episodes for alcohol), cannabis (71 per cent), amphetamines (70 per cent), and heroin (65 per cent). Clients whose principal drug of concern was heroin or amphetamines generally spent longer in treatment; the median duration of episodes was 29 days compared to 23 days for all treatment episodes.\(^\text{12}\)

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[6] Identified need: Insufficient detox services

Key issue

The needs assessment highlighted detox facilities and services as very important in the rehabilitation process and there was limited availability within the region. It was highlighted that whilst residential rehab facilities require clients to have undertaken some form of detox prior to admission, it is acknowledged that this does not necessarily always occur.

Description of evidence

The need to ensure that a coordinated approach by key stakeholders to ensure that there were residential detox processes available as an option to day detox was identified in the stakeholder feedback. Issues identified as problematic for day detox include; family responsibilities therefore no ‘space’ for concentrating on AOD, daily return to home/community environment where unhealthy AOD events continue (binge drinking), and after hours support.

[7] Identified need: Increased consumption of alcohol and other drugs in rural and remote communities

Key issue

The needs assessment highlighted the significant increased consumption of alcohol and other drugs within the rural and remote areas within the region.

Rural people experience disproportionately high levels of alcohol misuse and its associated burden of disease and injury. This is due to a range of factors characteristic of rural areas including lack of venues for recreation, stoic attitudes about help-seeking, economic and employment disadvantage, and less access to healthcare professionals and alcohol treatment services.13

About one-third of the Australian population (or 6.6 million people) live in rural and remote areas. In those areas, alcohol consumption and its associated harms are consistently higher than in urban areas.

The AIHW has reported that among those living in rural areas, men and youths are particularly likely to drink at high-risk levels. Those working in the farming industry are also more likely to drink at risky levels.

13 National Rural Health Alliance (2014) Fact Sheet: Alcohol Use in Rural Australia March 2014
Description of evidence

The 2013 National Drug Strategy Household Survey indicates that people in living in remote and very remote areas were twice as likely as people in major cities to smoke tobacco daily, drink alcohol in risky quantities and have used meth/amphetamines in the previous 12 months.\textsuperscript{14}

Compared to non-Indigenous people, Aboriginal and Torres Strait Islander people (two-thirds of whom live in rural and remote areas) are 1.5 times more likely to drink at risky levels for both lifetime and single-occasion harm. This is despite the fact that Aboriginal and Torres Strait Islander Australians are also 1.4 times more likely to abstain from drinking alcohol.

From 1990–2001, alcohol-attributable death rates were consistently higher for rural residents than urban residents (2.2 per 10,000 persons compared with 1.7). Similarly, rates of hospitalisation attributed to alcohol were higher for rural than urban residents (48 per 10,000 compared with 37). In rural areas, one-third of those aged 14–19 years and two-thirds of those aged 20–24 reported that they have been victims of alcohol-related physical abuse. In some Queensland mining communities with neighbouring work camps housing ‘fly-in, fly-out’ workers, the rate of alcohol-fuelled violence is significantly higher than the state average.\textsuperscript{15}

\[8\] Identified need:

Greater support for individuals transitioning from prison/rehab to community (both adult and youth)

Key issue

The needs assessment identified the lack of coordination of services and support for individuals and their families when leaving prison. This includes returning to community or to rehabilitation facilities.

In most areas within the region there is no systematic linkages to primary care or other services for prisoners returning to community.

Within the NQPHN region there is over-representation of the homeless, Aboriginal and Torres Strait Islander people, those with mental disorders, and those with intellectual disability in the correctional system. Release and return to community has been identified as a major period of vulnerability.

\textsuperscript{14} Australian Institute of Health and Welfare (2014)
\textsuperscript{15} Queensland Corrective Services: Alcohol and Drug Policy
Description of evidence

Stakeholder consultations and responses to the online survey identified a significant need in relation to the engagement of released prisoners with primary care. This included follow up in all communities within the region including remote communities. Suggestions included the need for services that provide an alternate ‘step out’/community reintegration facility for prison release including care-coordination.

This link between drug and alcohol use and risk-taking behaviours leads to increased contact with the criminal justice system.

Evidence suggests a strong link between drug use and offending. Between 37 per cent and 52 per cent of adult offenders report their criminal activity is directly attributable to their drug problem.

Studies identified by Corrective Services Queensland include:

- fifty one per cent of men and 35 per cent of women identified alcohol and/or drugs as the cause of their lifetime offending career
- twenty nine per cent of offenders attributed their most serious current offence to drug and/or alcohol intoxication and 24 per cent of offenders causally attributed their offending to drug and alcohol dependency
- seventy per cent of juvenile detainees were intoxicated at the time of their offence
- homicide and assault offences were more likely to be attributed to alcohol intoxication while property, fraud and multiple offences were likely to be attributed to reported illegal drugs
- alcohol is involved in approximately half of all violent crime
- there is a high level of illicit drug use among offenders prior to their entry to the correctional system. 71 per cent of prison entrants had used illicit drugs during the 12 months prior to their incarceration, with 60 per cent reporting a history of injecting drug use. For male offenders, the most commonly used drugs in the community include cannabis, heroin, amphetamines, ecstasy and hallucinogens. However, female offenders tend to use harder drugs like heroin, amphetamines and cocaine and abuse prescription medications.

Cairns has one of the highest proportions of chronic and recidivist young offenders in Queensland. From 2004 and 2012, juvenile property offences had increased from 33 per cent to 54 per cent, while sexual offences by Aboriginal and Torres Strait Islander juveniles increased from 9 per cent to 16 per cent (QPS 2013).
[ 9 ] Identified need:
Higher rates of risky alcohol consumption

Key issue

The needs assessment identified in some areas in the NQPHN region that there is a high rate of people consuming alcohol and other drugs at harmful levels, which results in some people displaying risky behaviours. Alcohol-related harm is not limited to individual drinkers but impacts families and the broader community. Alcohol is consumed widely in Australia. However, harmful levels of consumption are a major health issue, associated with increased risk of chronic disease, injury and premature death.18

The harmful use of alcohol has both short-term and long-term health effects. In the short term, the effects are mainly related to injury of the drinker or others that the drinker’s behaviour affected. With its ability to impair judgment and coordination, excessive drinking contributes to crime, violence, anti-social behaviours, and accidents. Over the longer term, harmful drinking may result in alcohol dependence and other chronic conditions such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems, and various cancers.19

High levels of AOD-related harm among Aboriginal and Torres Strait Islander Australians are both a consequence of, and contribute to, the health and social gap between them and non-Indigenous Australians.20

Description of evidence

Levels of risky drinking vary across HHSs (Health of Queenslanders 2014). Based on those exceeding Guideline 1 (two or less standard drinks on any one day) and Guideline 2 (four or less standard drinks on any one occasion), in 2011-12 compared to the state prevalence:

- Guideline 1—three HHSs in the NQPHN had higher rates (Cairns and Hinterland was 23 per cent higher, Mackay 31 per cent higher, and Cape York and Torres Strait 34 per cent higher)
- Guideline 2 (weekly)—Cairns and Hinterland, and Mackay were 35 per cent higher.

As identified in the community consultations within the NQPHN region, alcohol is the most commonly cited (65 per cent) principal drug of concern.

Rates of risky consumption of alcohol and other drugs (AOD) and related harms among Aboriginal and Torres Strait Islander Australians are generally twice those in the non-Indigenous population.21

The AIHW (2014) reported:

- about 1 in 5 recent drinkers aged 14 or older put themselves or others at risk of harm while under the influence of alcohol in the previous 12 months with driving a vehicle the most common activity undertaken (12.2 per cent of recent drinkers).

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Identified need:
Needs of marginalised groups within the region

Key issue

Some Culturally and Linguistically Diverse (CALD) populations may have higher rates of, or are at higher risk of, drug use. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia’s more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting.

People from disadvantaged or marginalised groups, such as gay, lesbian, bisexual, transgender, and intersex populations, may also experience more difficulty in accessing drug treatment and achieving successful outcomes from that treatment unless it is appropriate for their particular needs. Those who are most at risk are people with multiple and complex needs. This may involve a combination of drug use, mental illness, disability and injury, family breakdown, unemployment, homelessness, and/or having spent time in prison.

Generally, Australia-wide rates of homelessness for Aboriginal and Torres Strait Islander Australians significantly outweighs that of the non-Indigenous population. The fastest growing group of homeless people are those living in severely overcrowded accommodation and at least 75 per cent of Indigenous homeless people live in severely overcrowded dwellings—more than double the figure for non-Indigenous people.

Within the NQPHN region, the needs of the homeless population in relation to drug and alcohol were identified as needing further exploration in collaboration with other government departments.

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24 Cairns Alliance of Social Services: Position Paper 2016
Description of evidence

The patterns of alcohol and other drug use in gay, lesbian, bisexual, transgender, and intersex populations communities differ when compared to the broader population, based on the limited data available that collect transgender, intersex, and sexuality indicators and non-LGBTI comparison groups. Risky alcohol use is higher among lesbian, gay, and bisexual (LGB) people than heterosexuals. The 2010 National Drug Strategy Household Survey (NDSHS) found that 26.5 per cent of homosexual/bisexual people, compared with 15.8 per cent of heterosexual people, reported weekly risky drinking, defined as more than four drinks on a single occasion.\(^\text{25}\)

In 2011, the NQPHN region (including Cape York and remote communities) experienced the seventh highest rate of homelessness in Australia. However, ABS data does not accurately reflect hidden homelessness such as overcrowding, couch sleeping and rough sleeping.

A priority area for Cairns Regional Council is addressing the needs of homeless people, in particular Cape York residents unable to return home.

Numbers of homeless people across the region from Australian Bureau of Statistics, 2012:

- Cape York and Torres Strait numbers are unavailable
- Cairns—2,303 homeless
- Mackay—893 homeless
- Townsville—1,591 homeless

Headspace Centre report for the NQPHN catchment for FY 2015/16 (YTD to 31/12/15) indicates 9.5 per cent of young people accessing centres within the region were homeless or at risk of homelessness.

[ 11 ] Identified need:
Impact of alcohol and other drugs on infants and children

Key issue

Fetal Alcohol Spectrum Disorder (FASD) is the most common, preventable cause of disabilities and brain damage in children; it is triggered by exposure to alcohol during pregnancy. FASD causes lifelong disability due to intellectual impairment.

FASD is the most common non-genetic cause of intellectual impairment in the western world. More children are born each year with FASD than with autism, spina bifida, cerebral palsy, and Down syndrome combined. Between 17 and 42 children are born in Australia each day with FASD, between 3 and 9 of these in Queensland. (Total births ABS 2013).

\(^\text{25}\) ACON, Health Outcome Strategy 2013 - 2018 - Alcohol and Other Drugs
Alcohol is one of many substances that can result in damage to the unborn child if used during pregnancy. Others include some prescription medications and tobacco, marijuana, cocaine, and other recreational drugs. To date NQPHN has no access to specific data relating to effects of mothers drug use on unborn children.

Description of evidence

Accurate data on the prevalence of FASD is needed to inform prevention strategies. At present there is no requirement to count or report FASD nationally.

Stakeholder consultations identified that among Aboriginal and Torres Strait Islander children in North Queensland, FASD has been identified as a major cause of impairment to normal physical and intellectual development. This also highlighted that it may be under-diagnosed because clinicians are reluctant to ask about prenatal alcohol exposure or to pursue potential diagnoses of FASD if positive.

It has been estimated that child FASD affects 1.5 per cent of Aboriginal and Torres Strait Islander babies born in Far North Queensland and in some cases as high as 3.6 per cent.

At a national level in the Aboriginal population, 23 per cent of birth mothers of Aboriginal children reported drinking alcohol in pregnancy. Whilst the rates of reported alcohol consumption in pregnancy are higher for non-Aboriginal women, Aboriginal women are more likely to consume alcohol at harmful levels. A Western Australian (WA) study of women who had given birth over a 10-year period, found that Aboriginal women were 10 times more likely to be diagnosed with an alcohol diagnosis when compared with non-Aboriginal women—23 per cent and 2.3 per cent respectively.26

[ 12 ] Identified need: Higher rates of cannabis use

Key issue

Cannabis was identified across the NQPHN region as a major drug of concern. As identified by the Queensland Crime and Corruption Commission, the cannabis market in Queensland is an established and stable market and cannabis use in Queensland is higher than the national average.27

A number of short and long-term health effects have been associated with cannabis use. These include increased heart rate; a decrease in motivation, memory and attention; decreased motor skills; respiratory issues; anxiety, paranoia, depression, psychosis, and addiction as well as the increased risk of developing more severe mental health disorders such as schizophrenia.

Description of evidence

In the NQPHN region the most commonly cited principal drug of concern is alcohol (65 per cent), followed by cannabis (28 per cent), and volatile solvents and amphetamines (2 per cent). This is consistent with the cumulative data which shows alcohol as the most commonly cited principal drug of concern (42 per cent), followed by amphetamines (24 per cent), and cannabis (23 per cent) (Queensland Network of Alcohol and Other Drug Agencies 2015).

Consultations identified that in some communities, cannabis is so common that it is de-problematised—but it is a major social and health issue.

Seventy three per cent of respondents to the online survey identified that cannabis is a main consumer substance of concern within the region.

[ 13 ] Identified need:
Impacts of methamphetamine use

Key issue

The needs assessment identified that the use of methamphetamines (ICE) by people in the region is impacting on families, friends and the broader community. The lack of information and difficulty in accessing services and help was also a key concern identified.

Within the state, access to culturally effective resources is difficult with most communities requesting local resources with localised content and contact information.

Consultations with services pertaining to ICE and other drugs, and perceived community knowledge, has determined that there are groups of concerned people within communities who want to collectively support each other and consider peer support as a good strategy. Community members across the region identified that they are struggling with how best to support their loved ones and are often reluctant to speak out for fear of their family member coming to the attention of the justice system and the often heavy handed approach that does not assist in dealing with this health issue.

Description of evidence

During the stakeholder consultations across the region, the most commonly cited principal drug of concern is alcohol (65 per cent), followed by cannabis (28 per cent), and volatile solvents and amphetamines (2 per cent). This is consistent with the cumulative data which shows alcohol as the most commonly cited principal drug of concern (42 per cent), followed by amphetamines (24 per cent), and cannabis (23 per cent) (Queensland Network of Alcohol and Other Drug Agencies 2015).

More than half the people entering treatment for their AOD use identified poly-drug use, with 63 per cent of people who identified amphetamines as their primary drug of concern also identifying other drugs of concern, most often cannabis (31 per cent) and alcohol (22 per cent).28

28 Queensland Network of Alcohol and Other Drug Agencies. NGO AOD Services - Northern Queensland
Community feedback identified the need for early support to families of people who have AOD issues to prevent breakdown of families and potentially child safety issues.

Eighty one per cent of respondents to the online survey identified that amphetamines/methamphetamines are a main substance of concern within the region.

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[ 14 ] Identified need:
Strengthen capacity of primary health care sector

Key issue

Community consultations across the AOD sector in NQPHN identified the need to strengthen the capacity of the primary health care sector to effectively manage a range of AOD issues. This was particularly highlighted in the Aboriginal Community Controlled Health Organisations. Capacity development activities included screening, brief intervention, counselling, and case coordination.

Description of evidence

Evidence suggest that AOD should be embedded across primary health care in line with a multidimensional concept of health that includes AOD and mental health, but which also encompasses domains of health and wellbeing such as connection to land or ‘country’, culture, spirituality, ancestry, family, and community.29

Furthermore, the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014–2019 identifies as its Priority One: ‘to build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander controlled services and its workforce…’ 30

Although very little evidence is available locally on strategies for ICE in Aboriginal and Torres Strait Islander communities, exploratory research funded by the Department of Health and Ageing highlighted the need for more training and development of staff in primary care health services and AOD services (DOH, 2008). The National ICE Strategy 2015 also highlighted the need to build workforce capacity as a key strategy by aiming to ‘ensure early intervention and treatment services are better equipped to respond to ICE and meet the needs of the populations they serve’.

30 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019
[15] Identified need:
Coordination between sectors to address dual diagnosis issues

Key issue
A mental illness concurrent with substance use tends to exacerbate both the mental illness and harmful substance use. Consultations within the region raised concerns that in some communities the mental health services do not always adequately assess substance use well, as alcohol and other drug services do not assess mental illness.

Description of evidence
Community consultations in all areas within the region identified concerns about the lack of coordination and collaboration between AOD and mental health services and the difficulties experienced by individuals with comorbid conditions accessing coordinated care and support.

Thirty five per cent of people who use drugs also have a co-occurring mental illness. Although people with mental illness benefit from alcohol, tobacco and other drug treatment, they have poorer physical and mental health and poorer social functioning following treatment than other people.

[16] Identified need:
Harmful use of alcohol and other drugs by young people

Key issue
The needs assessment highlighted the concern across the NQPHN region around the harmful use of alcohol and other drugs by young people and the impact that this has on family and friends.

Stakeholder feedback indicated that existing services were already at capacity to support young people.

Young people within the NQPHN region face very complex social issues, some of which are particularly relevant to Aboriginal and Torres Strait Islander young people, as well as the ongoing complexities caused by high youth unemployment rates and homelessness.
Description of evidence

Evidence suggest that young people in the NQPHN region are significantly disadvantaged in relation to their Queensland counterparts. In 2011, 36 per cent of residents were in the most disadvantaged quintile, while in the discrete Aboriginal and Torres Strait Islander communities, 100 per cent were in the most disadvantaged quintile (ABS 2013).

In July 2015 Cairns had the highest youth unemployment rate for Queensland at 22.1 per cent.

Anecdotal and quantitative evidence from service providers within the region suggests that substance abuse and contact with the justice system have increased amongst Aboriginal and Torres Strait Islander young people over the past few years. This is believed to be symptomatic of broader social problems within the community. Government reports show that the region experiences high rates of youth suicide; completion rates for high school or further training are low; and the teenage birth rates are high. In addition, Cairns has the second highest rate of youth justice orders in the State; high levels of homelessness and high unemployment rates (Department of Communities, Social Planner 2010).

Consultation feedback identified the concerns as:

- Serious issues in relation to poly drug use amongst groups of vulnerable young people in the region
- Significant issues with community safety and public amenity relating to young people and drinking alcohol and inhalant use
- Lack of programs for young people to reduce risks associated with drug and alcohol misuse
- Lack of treatment and rehabilitation services for youth and in particular services that meet the needs of Aboriginal and Torres Strait Islander youth from rural and remote locations.

Escalation in methamphetamine use and dual diagnosis issues was reported across the region.

[17] Identified need:

Insufficient monitoring and evaluation systems and processes

Key issue

At this stage there is insufficient systems and processes across the region to ensure that sufficient data is being collected and collated to measure impact of the service provision across the NQPHN footprint. Relationships, partnerships, and collaborative arrangements are being established across the NQPHN region. As these further develop, systems will improve.

Description of evidence

There is a need for NQPHN to further develop links at both a state and local level to capture data and information to further understand the responsiveness, effectiveness, and overall performance of the mental health service system within the region.

21 Cairns Alliance of Social Services: Position Paper 2016
Outcomes of the service needs analysis
[1] Identified need:
Better integration and coordination between sectors and services

Key issue

Lack of coordination and communication between services and sectors that is impacting on continuity of care.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:

- increase service delivery planning and integration at a local level
- lack of cross-sector structures and support mechanisms—e.g. AOD treatment needs to link with employment support to jointly support transitions to employment
- recent consultations with Clinical Councils in the Northern Queenslan Primary Health Network (NQPHN) region identified similar concerns as stakeholders in the region.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:

- identify and promote referral pathways that enhance access to wrap-around services that support individuals, families and communities; engage in local level AOD/ICE planning
- improve coordination of AOD and related services between sectors
- coordinate with existing services to avoid overlap and expand capacity to accommodate all individuals in need of treatment
- co-locate mental health and AOD services as a strategy to improve coordination
- need for a central organisation to co-ordinate regular communication between all AOD services. Currently state-based organisations do not necessarily communicate to all stakeholders—e.g. government and NGOs
- improve integration and collaboration between health services and other services e.g. housing, health, employment, education
- adequate funding and resources required to provide evidence-based, sufficient, and timely initiatives with a focus on the provision of resources to the AOD treatment sector.

Analysis of local service planning reports and initial service mapping activities:

- need for increased opportunities for Aboriginal and Torres Strait Islander communities to develop their own AOD local area plans and strategies
- service mapping did not include details regarding existing coordination and collaborative mechanisms.

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32 Queensland Network of Alcohol and Other Drug Agencies. NGO AOD Services – Northern Queensland
[ 2 ] Identified need:
Support and expand appropriate services for Aboriginal and Torres Strait Islander people

Key issue

There is a need to improve access for Aboriginal and Torres Strait Islander people experiencing AOD harm by supporting, enhancing, and expanding service options for Aboriginal and Torres Strait Islander people.

There is a need to build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce to manage individuals and families with AOD issues.

Integral to building the supply of an Aboriginal and Torres Strait Islander AOD workforce is the need to ensure staff are suitably trained and supported.

Description of evidence

Feedback from stakeholder and community consultations identified the need to:

- the need for more Aboriginal and Torres Strait Islander staff with AOD skills to improve access for Aboriginal and Torres Strait Islander people
- very limited specified positions for Aboriginal and Torres Strait Islander people locally particularly in general practice
- Aboriginal and Torres Strait Islander staff employed can feel isolated and experience burn out due to high workloads. It was suggested that more Aboriginal and Torres Strait Islander staff would support more culturally appropriate responses and approaches to AOD treatment and harm minimisation.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:

- lack of dedicated AOD positions within the Aboriginal Community Controlled Health Organisations
- there is need for strategies that grow an Aboriginal and Torres Strait Islander AOD workforce (QAIHC) as currently there is a labour skills shortage
- the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014-2019 identified the need to ‘build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce services’ as a key priority area33
- need for a clear career pathway for Aboriginal and Torres Strait Islander AOD workers
- need for skilled Aboriginal and Torres Strait Islander primary health care workforce with confidence to deliver AOD support.

33 National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014 - 2019
[ 3 ] Identified need:
Need for additional treatment capacity and equitable distribution within the specialist AOD sector across the region, in particular rural and remote areas

Key issue
Demand for AOD services exceeds supply throughout the region. There are only a few non-government organisations currently operating services within the region in addition to the region specific services provided by the HHSs. In some rural and remote sites there are isolated workers with minimal support structures.

Description of evidence
Feedback from stakeholder/community consultations and online survey identified:
• increase the range and accessibility of AOD treatment services across all areas within the region. Universally cited issue across all HHS regions
• ICE is an emerging issue—it is accessible and cheap; alcohol, marijuana, tobacco are other problem drugs. Areas within Mackay and Townsville regions in particular identified a rise in ICE related issues
• FASD is still a big issue and not being addressed across the region
• in general across the NQPHN region, it was identified a need for: increased capacity in residential rehabilitation services; increased availability of diversionary, case management and assertive outreach programs—particularly for young people and people from Aboriginal and Torres Strait Islander backgrounds; increased availability of residential detox facilities; AOD health promotion; AOD services in rural areas
• need for services targeting women including maternal and child health services. This was particularly noted as a need for Aboriginal and Torres Strait Islander women within the Cairns, Cape York and Torres Strait regions
• recent consultations with Clinical Councils in the NQPHN region identified similar concerns as stakeholders in the region
• twenty eight per cent of respondents to the online survey identified that drug and alcohol treatment needs in their region are being met ‘not at all’. Fifty three per cent of respondents identified that these treatment needs are being met ‘somewhat’. Respondents identified youth, Aboriginal and Torres Strait Islander people, and people in rural and remote areas as those most in need of AOD services.
Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:

- an increase in demand of clients with more complex issues including co-morbidities (mental health and chronic disease) and poly drug addiction
- a lack of residential rehabilitation services across Queensland and lack of dedicated AOD positions within the Aboriginal Community Controlled Health Organisations (specifically for ICE)
- demand for residential detox facilities to ensure a transition pathway to rehab facilities
- enhance health professionals’ skills to deliver AOD intervention—in both the primary health care and emergency settings
- increase workforce development for the AOD sector and create a sustainable AOD workforce that is capable of meeting future challenges.

Analysis of local service planning reports and initial service mapping activities:

- an underinvestment in the specialist AOD treatment sector across the NQPHN region with a particular need for additional services in the rural areas
- as identified by QNADA, there are a few non-government organisations currently operating services within the region in addition to the region specific services provided by the HHSs.

The service mapping indicates limited specialist AOD services within the region, especially outside of the major regional centres. The regularity of QH AOD services to rural, remote and remote Aboriginal and Torres Strait Islander communities in unknown, as is the extent to which they provide support to youth. The service mapping indicates that there are only a handful of community-based AOD counselling and support services across the NQPHN region, and none in the rural towns and remote and remote Aboriginal and Torres Strait Islander communities.
Identified need:
Additional capacity within rehab facilities—including additional capacity to support the particular needs of individuals and families

Key issue

Limited available rehab facilities with the region and the existing facilities do not have capacity to cater to the particular needs of individuals and families needing treatment.

Description of evidence

Feedback from stakeholder and community consultations identified:
- a need to increase the access and availability of rehab facilities. These issues were of concern across the whole NQPHN footprint. There are often waiting lists, so critical opportunities for engagement are missed
- concerns were expressed about the cultural competency of some services—with low Aboriginal and Torres Strait Islander client numbers at some facilities
- feedback and discussion around the existing facilities identified that some of the existing facilities may not be utilised in a way that currently meet the needs of the communities
- a need to increase access to primary health on-site for residential rehabilitation services; address physical health, child and maternal health, and SEWB in addition to substance use
- a need for residential rehab facilities to support specific groups (e.g. youth, women, families, Aboriginal and Torres Strait Islander people)
- a need to work with families to support people through the rehab journey—all programs need to be holistic
- seventy five per cent of respondents to the online survey identified rehab services as being required locally to address the needs of those who are missing out on services.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
- lack of residential rehabilitation services across Queensland
- demand for residential detox facilities—too problematic with day detox process
- facilities where there are large numbers of Aboriginal and Torres Strait Islander clients that are not accessing service—funding bodies support culturally effective inclusive strategies
- current family-centred facility requires Indigenous governance to ensure culturally safe and effective strategies are implemented.

Analysis of local service planning reports and initial service mapping activities:
- need increased capacity in residential rehabilitation services—including peer support and after-care support services
- need culturally appropriate residential rehabilitation services to effectively meet the needs of young people from rural and remote locations
- there are limited rehab facilities in the region, and no facilities for youth.
Identified need:
Need for additional detox facilities in the region that provide services for specific population groups such as youth and women

Key issue
Very limited in-patient detox facilities in the region.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• across the region the need for additional detox facilities was identified. Whilst some feedback from individuals was around the suitability of day detox, others identified that the need was in relation to residential detox facilities as it was hard to do day detox then go home to same situation at night
• the Torres Strait identified a need to have local access to detox and well as rehab facilities
• respondents to the online survey identified that withdrawal management services are the principally needed services to address the needs of people who are missing out on services in the region—closely followed by rehab services and counselling.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
• funding to support detox beds are made available for specific facilities to trial with a long term focus on further investment
• increase access to AOD treatment and support services for young people
• funding to support integrated service provision to vulnerable young people.

Analysis of local service planning reports and initial service mapping activities:
• need increased availability of residential detox facilities
• culturally appropriate detoxification services to effectively meet the needs of young people from rural and remote locations.
Identified need:
Need for AOD services for young people

Key issue
Not enough AOD services and workers to support young people—especially in rural and remote communities.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• across the whole region the need for additional services and service capacity was identified
• there are no rehab services for young people within the region
• serious issues in relation to poly drug use amongst groups of vulnerable young people in the region; significant issues with community safety and public amenity relating to young people and drinking alcohol and inhalant use; escalation in methamphetamine use and dual diagnosis issues in Cairns, Townsville, and Mackay
• long waiting lists exist for QH youth AODs
• no specialised AOD services in Cape York for young people
• difficult to access AOD counselling in rural areas
• need increased access to AOD services for young people; more education in schools; youth groups; prevention and early intervention; culturally appropriate ways to connect with Aboriginal and Torres Strait Islander young people; in conjunction with AOD treatment, young people often also require support with rebuilding their relationships with family and community
• respondents to the online survey identified youth as the group most in need of AOD services.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
• a clear need to increase youth related AOD services within the NQPHN region with a focus on afterhours care/programs
• research into a successful model for outstation/homeland programs for at risk young people
• support AOD youth focused workforce to deliver family responsive information/resources.

Analysis of local service planning reports and initial service mapping activities:
• need for diversionary programs for young people aimed at supporting young people to reduce risks associated with drug and alcohol misuse; treatment and rehabilitation—including culturally appropriate detoxification and residential rehabilitation services to effectively meet the needs of Aboriginal and Torres Strait Islander youth from rural and remote locations; case management and assertive outreach programs.

Within the NQPHN region, there is one Queensland Health youth Aboriginal and Torres Strait Islander specific AOD service located in Cairns, however aside from this, as mentioned above, the extent to which QH AODs provide support to youth is unknown. This is particularly so within the less populated rural areas, and the remote and remote Indigenous areas where all AOD services are provided through outreach. The service mapping indicates that there are only two community-based youth AOD services (one in Cairns and one in Mackay) across the NQPHN region. As highlighted elsewhere, there are no youth rehab facilities in the region.
[7] Identified need: Establishment of services and stronger support mechanisms for individuals transitioning from prison to rehab/community (both adult and youth)

Key issue

There are no systematic linkages to primary care or other services for individuals transitioning from prison to rehab or back to community.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• this key service need was identified across the region. This included the need for post release programs (from rehab and prison)—including care-coordination and a step out/community reintegration facilities for individuals on release from prison
• support for prisoners needs to include provision of AOD treatment within the prison setting as also identified.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
• a coordinated approach between QCS, rehab facilities and other government and NGOs to transition across AOD services
• provide greater support to clients transitioning from prison, including provision of AOD treatment within the prison setting e.g. step in-step out facilities and programs.

Analysis of local service planning reports and initial service mapping activities:
• build and strengthen partnerships with key agencies to advise and provide support to address AOD harm among offenders.

The service mapping indicates that there are no specific services targeting this issue. However, more detailed and localised service mapping is required to better understand the localised service systems.
Identified need:
Additional service capacity required within the region to respond to ICE

Key issue

Many services within the region feel unequipped to effectively support people using ICE. This included primary health care services as well as NGOs and rehab services.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• whilst this issue was raised across the region, the Mackay area identified the greatest concerns. The lack of services, information, and support in dealing with the impacts of ICE addiction was identified.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
• ICE information for family/community members is available in plain language statements
• organisations offer advice and referral to support both clients and family/community—people do not know what to do if they do not know where to go to seek help
• the use of localised information about ICE support is needed—flyers/education/helplines
• school-based education about ICE
• use of existing/emerging local networks to support information delivery—e.g. sport clubs/PCYC/art and culture activities.

Analysis of local service planning reports and initial service mapping activities:
• the service mapping indicates that there are no services providing these services
• however, more detailed and localised service mapping is required to better understand the localised service systems.
[ 9 ] Identified need: Additional services and support for families and carers of AOD users—particularly ICE

Key issue

The need for increased services and support for families/carers for ICE users was identified as a key area of service need. Consultations identified that approaches that would meet the needs included support groups, counselling and also peer support.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• families identified that they were struggling with what to do and how best to support their loved ones. This was particularly highlighted in the Townsville and Mackay region. They identified the need for the establishment of family support groups in major northern centres as well as services to the families of people who have AOD issues—to avoid the breakdown of families and/or intervention by Child Safety.

Analysis of local service planning reports and initial service mapping activities:
• the initial service mapping identified that most NGOs provide what they can as part of their service, however there are no organisations specifically funded to provide this.
Identified need:
Additional services and increased service capacity in relation to health promotion, early intervention, and prevention

Key issue
A need to increase the availability and services around alcohol and other drugs information and educational sessions was identified across the region. This was highlighted as a need to increase services and groups for men across Cape York and the Torres Strait.

Description of evidence
Feedback from stakeholder/community consultations and online survey identified:
- ICE education/training or training is required around re-emerging drug issues—community members wanting to form AOD groups to learn more
- need for localised resources to provide health education about AOD issues
- need for health promotion/early intervention services, including educational programs (e.g. men's groups).

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
- funding opportunities for health promotion and health education programs with localised content needed
- frontline workers require regular upskilling in areas of emerging AOD issues.

Analysis of local service planning reports and initial service mapping activities:
- need for additional AOD health promotion across the region but in particular rural and remote areas.

The service mapping indicates that there are very few AOD services providing AOD health promotion and early intervention and prevention. However more detailed and localised service mapping is required to better understand the localised service systems, as this may be part of the general primary health care health education program.
Identified need: Increase the supply of AOD workers

Key issue

The needs assessment identified a lack of specific alcohol and other drug workers across the region particularly in rural and remote areas and the Torres Strait.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
- consistent message from consultations and online survey was the lack of specific AOD workers in many areas within regions. This was particularly noted as a priority for rural/remote communities and the Torres Strait.
- QH AOD teams in some HHS regions had reduced capacity over recent years (e.g. Mackay, Cape/Torres, Townsville).
- survey results indicated that 50 per cent of providers specifically identified the need for psychology services and 50 per cent for Aboriginal and Torres Strait Islander mental health workers to address workforce gaps in AOD.
- Seventy two per cent of respondents to the online survey identified AOD counselling as being required locally to address the needs of those who are missing out on services.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
- Queensland Aboriginal and Islander Health Council and the Queensland Indigenous Substance Misuse Council as the respective peaks for Aboriginal and Torres Strait Islander Community Controlled Health and AOD services identified the need to ‘lobby for resources to meet current and emerging service demand’ as a key sector priority.
- local experts including QAIHC supported the need to grow a local workforce, in particular Aboriginal and Torres Strait Islander AOD workers.
- experts locally and from peak bodies believe that this unmet need is accurate for the NQPHN region.
- the need to build the capacity of Aboriginal and Torres Strait Islander mental health workers and further develop more effective models to meet the needs of the community is required.

Analysis of local service planning reports and initial service mapping activities:
- the New Horizons Report, a national review of alcohol and other drug treatment services in Australia identified a ‘substantial unmet demand’ (p.183). The research estimated that approximately 200,000 people receive AOD treatment in any one year in Australia. At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year.24

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Identified need: Increase the capacity of the existing AOD workforce to better support people experiencing AOD issues

Key issue

NGO AOD workers across the region identified the need to increase their skills and capacity to effectively treat and support people experiencing AOD issues. On-site training for residential rehab facilities should be considered as staff often have difficulty in being released to attend training due to backfilling.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified the following key training priorities:

- working with complex trauma
- cultural competence—culturally appropriate responses and approaches to AOD treatment and harm minimisation as traditional approaches are not always very useful
- ensuring all staff have formal qualifications—several organisations would like to support all staff to complete Cert IV or higher in AOD qualifications
- ICE and other emerging drug issues
- withdrawal support
- training for pharmacists (e.g. mental health first aid) and identification of at-risk patients to refer to AODs
- dual diagnosis.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:

- need for a coordinated approach to AOD workforce support and development
- training and professional development for front line staff is critical
- there is a range of training being delivered by key agencies including INSIGHT Training and Education Unit, Queensland State Government and Dovetail, however, one of the challenges lies with staff shortages not enabling staff to be released for training; or high staff turnover resulting in a constant need for upskilling
- on-site training/upskilling for AOD workforce e.g. digital/RTO on-site—addresses issues of staff attendance
- front line staff require information/skilling/debrief/supervision/mentoring about emerging AOD issues on a regular basis.

Analysis of local service planning reports and initial service mapping activities:

- workforce mapping indicated that there is a need for improved training pathways including developing strategies and pathways into the VET and university sector.
Identified need:
Increase the capacity of GPs and other primary care and community sector workers to better support people experiencing AOD issues

Key issue

GPs and other primary care and community sector workers lack capacity to effectively support those with AOD issues. Currently there are no primary healthcare guidelines for working with Aboriginal and Torres Strait Islander communities around drug and alcohol issues that are followed across the region. The AOD workforce comes from a wide variety of backgrounds and the health care services require support around service delivery and service delivery models to embed drug and alcohol services within their primary healthcare services.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
• widely noted issue across the region. GPs and psychologists usually have limited training in AOD
• feedback from service providers in the primary healthcare sector indicated staff felt they had a lack of skills and confidence in addressing drug and alcohol issues with individuals and families
• training priorities included use of screening and assessment tools, brief interventions, motivational interviewing, stages of change model, and understanding referral options
• other service needs included ensuring more GPs and pharmacists are qualified to run opioid programs need to embed AOD workers in GP practices and the need to upskill workers in new/emerging drugs (ICE).

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
• AOD intervention training for all frontline staff including administration, primary health care, general practice and allied health staff
• increase AOD workforce in primary health care and general practice facilities.

Analysis of local service planning reports and initial workforce mapping activities:
• the need to increase opportunities for student placements in AOD settings during vocational, undergraduate and post graduate education by supporting local universities to establish AOD student placement options.
Identified need: Sustainable AOD workforce

Key issue

Difficulties with retention of staff—which impacts on continuity of care and provision of services was identified as a key service issue. There is a need for strategies to retain workers in AOD workforce including ensuring; support for to debriefing and ensure wellbeing; ensure staff have access to professional development, supervision and mentoring.

There is a need to support:
- systems to provide adequate supervision and support; including policy and procedure for staff to access debriefing, counselling, and employee assistance programs
- systems to ensure adequate continuing professional development.

Organisation have structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety. A percentage of PHN funds would be allocated to enable this to occur.

Description of evidence

Feedback from stakeholder/community consultations and online survey identified:
- across the whole region issues with retention of staff were identified. These included high workload, lots of staff burn out, limited access to debriefing, counselling, lack of clear training pathways and career pathways as well limited structured continuing professional development
- another issue identified as contributing to staff turnover for Aboriginal and Torres Strait Islander staff was a lack of cultural safety within organisations they were employed in.

Feedback from peak statewide agencies, local experts, and NQPHN Clinical Councils identified:
- QAIHC identified high burn out rates as a key issue and suggested wage parity based on qualification and skill levels was required; along with more opportunities to access VET training (Diploma Level Qualifications) to meet the complex needs of presenting clientele
- need for a clear career pathway for AOD workers.

Analysis of local service planning reports and initial service mapping activities:
- need a sustainable AOD workforce in the NQPHN region that is capable of meeting future challenges, innovation, and reform
- a key service need identified locally was the need to ensure all organisations had structured continuing professional development systems in place for their staff.
Identified need: Insufficient monitoring and evaluation systems and processes

Key issue

At this stage there are insufficient systems and processes across the region to ensure that sufficient data is being collected and collated to measure impact of the service provision across the NQPHN footprint. Relationships, partnerships and collaborative arrangements are being established across the NQPHN region. As these further develop, systems will improve.

Description of evidence

There is a need for NQPHN to further develop links at both a state and local level to capture data and information to further understand the responsiveness, effectiveness, and overall performance of the regional AOD service system.
Moving forward

Service evaluation and quality improvement are an integral component of the Northern Queensland Primary Health Network (NQPHN) commissioning cycle. NQPHN will be using all of the information within this document to inform the commissioning of services to meet the highlighted needs of North Queensland communities.

Following implementation of these new service models, further consultation will be undertaken with communities to ensure that the intended outcomes of these initiatives are being met.

Thank you to all individuals and services who contributed to the preparation of this document. NQPHN looks forward to further engagement with the people of North Queensland to improve the primary health outcomes of our region.