Government of **Western Australia**
Mental Health Commission

Alcohol and Other Drug Services in the Kimberley

Consultation Discussion Paper

August 2018

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The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander People as the Traditional Custodians of this country and its waters. The Commission wishes to pay its respects to Elders past and present and extend this to all Aboriginal people.

Disclaimer

The information in this document has been included in good faith and is based on sources believed to be reliable and accurate at the time the document was developed. While every effort has been made to ensure that the information contained within is accurate and up to date, the Mental Health Commission and the State of Western Australia do not accept liability or responsibility for the content of the document or for any consequences arising from its use.

1. Background

The State Government has committed to expand specialist drug services into rural and regional areas of need including in the Kimberley, as part of its Methamphetamine Action Plan (MAP) 2017 election commitments. The MAP outlines the government commitment to reduce the demand, harm and supply associated with methamphetamine use.

In order to progress the election commitment, Royalties for Regions funding of $200,000 has been allocated to the Mental Health Commission (MHC) in the 2017-18 Budget to plan for the expansion of alcohol and other drug (AOD) (and co-occurring mental health) services in the Kimberley and to develop a business case.

While the discussion paper primarly focusses on the expansion of AOD services, it is recognised that consideration should be given to services that address co-occurring mental health, AOD issues.

The funding of $200,000 has been provided for consultation, planning, analysis and modelling of AOD services in the Kimberley to inform the development of a business case for the consideration of the State Government in the 2019-20 Budget process.

This discussion paper provides a guide for the consultations regarding the optimal mix of AOD services for people living in the Kimberley and includes a series of key consultation questions for guided input.

Consideration is given to ensuring an appropriate mix of AOD services aligned to the Western Australian Mental Health, Alcohol and Other Drug Sevrices Plan 2015-2025 (the Plan) in the service streams of prevention, community support, community treatment, community bed based services (including withdrawal and residential rehabilitation services) and hospital based services. The aim is to plan for comprehensive and integrated AOD services in the Kimberley.

The paper does not intend to provide detailed comment on how the AOD services are operating ‘on the ground’.

2. Purpose of Discussion Paper

This discussion paper provides an overview of the key current AOD services funded by the MHC, as well as through the Commonwealth, including those receiving funding through the WA Primary Health Alliance (WAPHA). It is recognised that there are many AOD services also provided through government, non-government organisations and private providers. This discussion paper does not provide an exhaustive list of all of these, however summaries key services and issues to aid in the faciliating discussions regarding current gaps.

Consultation questions are also enclosed to guide input into the recommendations for future services development.

The MHC has considered the services currently provided in the Kimberley region and, based on this information, together with treatment data and gaps analysis, has identified areas where service provision in the Kimberley may be enhanced (based on service type and/or by priority population groups).

Stakeholder consultation is being undertaken in relation to the options that have been identified as potential for service development. It is intended that the consultation will seek input into the overarching priorities for service expansion in the Kimberley, as opposed to prescribing the specific operational models of service delivery. Subject to future Government funding, the operationalisation of services will include localised services development to ensure the delivery of appropriate models of service.

The MHC has also considered the outcomes of previous AOD consultations undertaken more broadly, and in the Kimberley region including (but not limited to) those for the Plan, and more recently by the MAP Taskforce.

It is noted that this project relates specifically to options to enhance AOD services, with the aim of improving the health and wellbeing of people in the Kimberley region. However, it is acknowledged that AOD use does not occur in isolation and that there are a number of social determinant factors that impact on and are intertwined with AOD issues including (but not limited to): mental health (social emotional wellbeing); housing; cultural disconnect; employment; education; child protection and family support; and interaction with the justice system.

Of particular focus are services for identified high priority groups including Aboriginal communities, youth, as well as for co-occurring conditions such as co-occurring mental health and AOD.

Furthermore, there are a number of issues that impact service provision in the Kimberley region that require specific acknowledgement. This includes areas such as: generational impact of colonisation on Aboriginal people; attraction and retention of a skilled AOD workforce, including the provision of a culturally secure workforce; efficient and sustainable service delivery and the distance to very remote communities; and challenges related to the coordinated commissioning of services and services development.

Forensic services are not considered within the scope of this discussion paper however it is noted that this will be subject to separate planning to be undertaken by the MHC in consultation with key stakeholders.

3. Election Commitments

As part of the 2017 election, the State Government committed to a state-wide, integrated MAP to reduce the demand, supply and harm from methamphetamine use, including allocating $45 million of new and existing funding over four years to deliver the key initiatives outlined in the MAP.

The MAP seeks to:

- Invest an additional $2 million per annum into treatment facilities to respond to early intervention and severe methamphetamine dependence.
- Expand specialist drug services into rural and regional areas of need and open two specialised rehabilitation centres, one in the South West and one in the Kimberley.
- Investigate ways to ‘fast-track’ guardianship and administration applications for those methamphetamine addicts who are no longer able to make their own decisions and need help to manage their affairs and their rehabilitation.
- Introduce a Mental Health Observation Area at Royal Perth Hospital emergency department.
- Work with drug and alcohol education agencies to ensure WA schools have the most up-to-date programs to better inform our young people.
- Ensure WA Police have the resources to significantly increase the volume of roadside alcohol and drug testing of WA drivers.
- Establishing a Taskforce to oversee the implementation of the MAP and ensure that coordination occurs across government.
- Create two dedicated drug and alcohol rehabilitation prisons, one for men and one for women to break the cycle of drug related crime in the community.
- Create a 10 person Prisoner Triage Unit to operate in those courts dealing with the greatest number of short sentence drug-related offenders.

The implementation of the MAP is being overseen by a Taskforce that has been established to ensure cross government coordination and to provide advice to Government on:

- improving how programs can be best delivered and targeted to areas of greatest need, including regional areas;
- opportunities for cross-sector collaboration to reduce methamphetamine harm, demand and supply; and
- advice on the best ways to measure the performance and success of the Government's initiatives.

The Taskforce has also undertaken stakeholder consultation with service providers, individuals, families, community and business representatives regarding specific issues facing communities, including in the Kimberley.

Funding allocated to the MHC as part of the MAP election commitments for continued and additional AOD services including:

- $16 million over four years from 2018-19 to 2021-22 for the continuation of 52 residential rehabilitation beds at existing residential rehabilitation service providers (24 beds in the metropolitan area and 28 beds in regional areas) and eight low medical withdrawal beds (four beds in the metropolitan area and four in regional areas). Funding for these beds will be provided to the MHC on an ongoing basis (i.e. beyond 30 June 2022);
- $9.306 million in operational funding in the 2018-19 Budget to contract residential rehabilitation and low-medical withdrawal services in the South West;
- $200,000 to identify and undertake planning and consultation required to address the gaps in AOD treatment services in the Kimberley; and
- $4.5 million through the 2017-18 Mid-Year Review process for the continuation of AOD community-based treatment, via the existing network of Community Alcohol and Drug Services (CADS), for individuals and families in priority locations until 30 June 2021.

This discussion paper relates specifically to the planning and consultation that will be undertaken regarding AOD treatment service provision in the Kimberley region to inform the development of a business case for consideration by the State Government as part of the 2019-20 Budget. Whilst, residential rehabilitation services are being explored, consideration is also being given to the suite of AOD services for the planning of a comprehensive and integrated system of services.

4. Strategic context

The National Drug Strategy 2017-2026 provides a national framework which identifies national priorities relating to alcohol, tobacco and other drugs. The Strategy is based on a harm minimisation approach (including a range of strategies to prevent and reduce drug related problems, and help people experiencing problems relating to their drug use) through the balanced implementation of the three pillars of supply reduction, demand reduction and harm reduction.

At the service delivery level, balanced investment in each of these strategies is required in order to deliver an effective AOD treatment system.

At a State level, the Western Australian Alcohol and Drug Strategy 2018-2022 is consistent with the National Drug Strategy (as well as other national and state policy directions), and provides guidance for government, non-government and the community in addressing the adverse impacts of AOD problems in Western Australia under the key areas of:

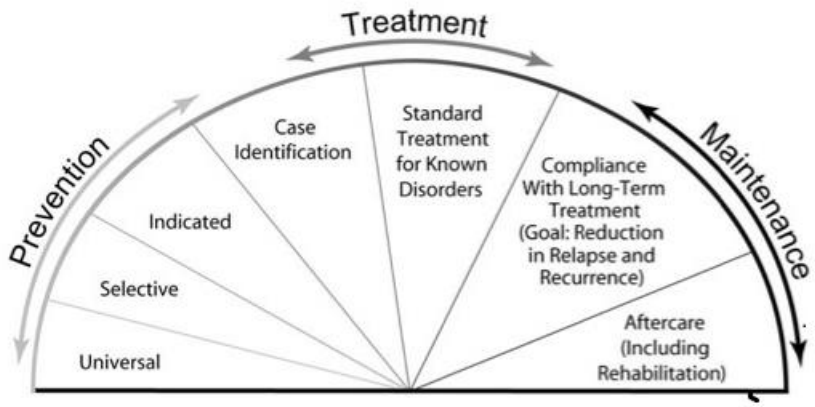
- Focusing on prevention;
- Intervening before problems become entrenched;
- Effective law enforcement approaches;
- Effective treatment and support services; and
- Strategic coordination and capacity building.

4.1 Alignment to the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

In December 2015, the MHC released the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan). The Plan outlines the optimal mix and level of AOD and mental health services required to meet the needs of Western Australians over the ten years, across a number of service streams including prevention, community support, community treatment, community bed-based and hospital based services.

This comprehensive approach is supported by evidence regarding effective AOD treatment which also demonstrates a range of services are required across the spectrum of prevention, through to treatment and supportive after care (as outlined in **Figure 1**).

Figure 1: Continuum of health care



ıurce: Reprinted with permission from Reducing Risks for Mental Disorders. Copyright 1994 by the National Academy of Sciences, Courtesy of the National Academy Press, Washington, DC.

A significant consultation process was conducted in the development of the Plan, including two consultation forums; one in Broome: and one in Kununurra.

Some of the AOD issues that were raised in these forums included:

- recognition of the statistically high proportion of AOD needs that are unique to the Kimberley region;
- the impact of alcohol as being a major challenge for the Kimberley region and a change in the drinking culture is required; specialist diagnosis, treatment and support for Fetal Alcohol Spectrum Disorder (FASD) is particularly important for the Kimberley region;
- the need to expand low-medical and hospital-based withdrawal services;
- greater number of residential rehabilitation services;
- more services for high risk youth, including withdrawal and residential services, that includes treatment and support for both AOD and mental health issues;
- increasing the range of AOD services offered in the community, including engaging with general practitioners (GPs);
- restricted access to services outside of major hubs and the need for greater coverage of community treatment services; and
- increased training and engagement for GP's in pharmacotherapy programs.

A copy of the Plan can be found at: www.mhc.wa.gov.au.

Prior to this, in 2014, the former Drug and Alcohol Office undertook consultation with stakeholders in the Kimberley to determine specifications for new Community Alcohol and Drug Services and to determine priorities for the Plan. Some of the key points raised in the Kimberley region in relation to AOD included:

- the social norms and acceptance regarding alcohol were noted, including the impact on the broad community;
- the perceived increase in the number of children at risk from AOD harm, and the need for dedicated and comprehensive services for this cohort; and
- greater support for people exiting residential rehabilitation and local options for withdrawal.

4.1.1 Plan Modelling and Gaps Analysis

The Plan recognises the need to provide a range of AOD and mental health services across the spectrum and the importance on rebalancing services between hospital-based and community-based services, to enable to stay connected to their families and significant others. Of particular importance, is providing services in regional areas, closer to where people live.

The Plan modelling is provided against a number of service streams:

- Prevention;
- Community Support Services;
- Community Treatment Services;
- Community Bed-based Services; and
- Hospital-based Services.

In the AOD sector, the Plan modelling suggests that there is relatively balanced service provision across the optimal mix of services (community to hospital services), compared to the mental health sector (see **Figure 2**). However, it is recognised that there needs to be a greater investment in AOD services across the optimal mix to meet population demand.

Figure 2: Current services as a proportion of 2014 demand (AOD).

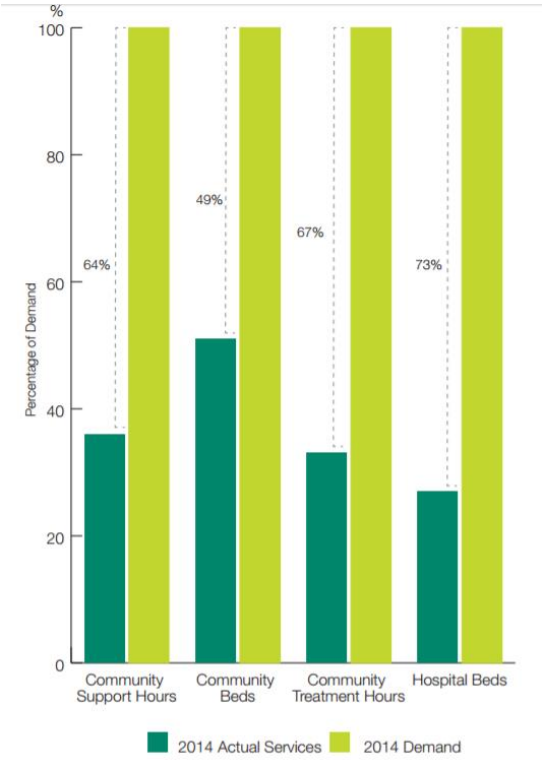


Figure 2: Current services as a proportion of 2014 demand (Alcohol and Other Drugs only)

For the Kimberley region, modelling for the Plan identified that:

- there is a need for more AOD resourcing across the service spectrum;[1]
- gaps exists in relation to the availability of community and hospital bed-based services which impacts on the number of people being able to access withdrawal services prior to entering residential rehabilitation;
- the hours of service dedicated to prevention needs to steadily increase; and
- the level of service needs to be adequate and appropriate to service the vast geographical size of the Kimberley region, rather than the population.

An overview of the Plan modelling, current resources provided and future demand is provided in Section 6 within the context of identifying gaps and opportunities.

[1] Future service demand is only available for 2025 at the regional level.

5. Environmental scan

5.1 Alcohol and other drug trends and related harm in the Kimberley region

In 2016/17, while alcohol remained the primary drug of concern for people in the Kimberley, the proportion of new treatment episodes where alcohol was the primary drug of concern declined from 73.6% in 2012/13 to 58.3% in 2016/17. This reflects State-wide trends where the proportion of new treatment episodes where alcohol was cited as the primary drug of concern decreased over the same period from 42.4% in 2012/13 to 32.7% in 2016/17. This was consistent across the range of treatment types (withdrawal, community bed-based and community treatment services).

The proportion of new treatment episodes where amphetamine-type stimulants[2] (ATS) were listed as the primary drug of concern in the Kimberley region tripled in the same period from 4.8% in 2012/13 to 15.0% in 2016/17.

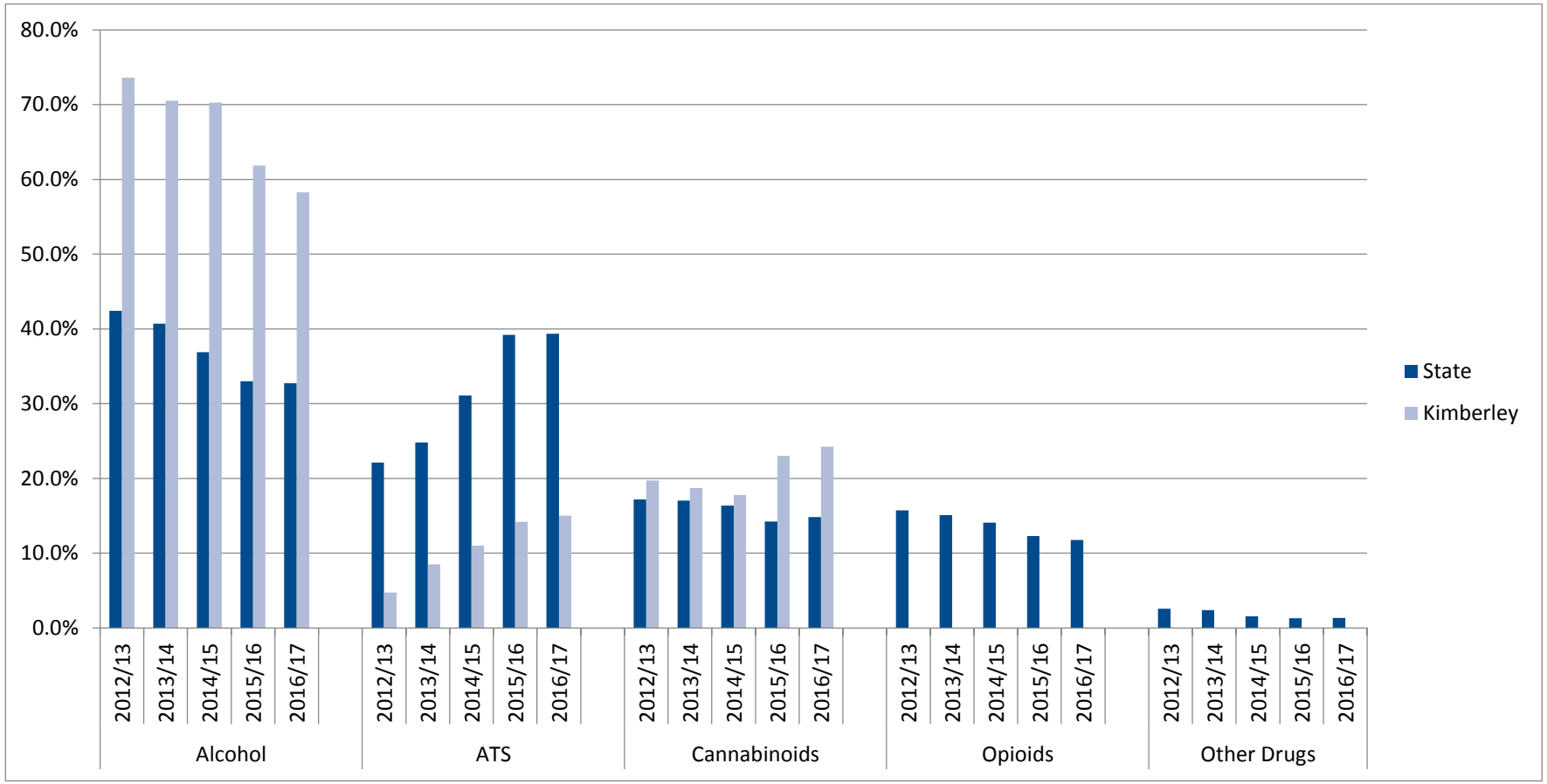
In comparison, the proportion of new treatment episodes where ATS were the primary drug of concern for people State-wide almost doubled from 22.1% in 2012/13 to 39.4% in 2016/17, overtaking alcohol as the primary drug of concern.

In addition, the proportion of new treatment episodes where cannabis was the primary drug of concern for people in the Kimberley also increased from 19.7% in 2012/13 to 24.2% in 2016/17.[3]

See **Figure 3** and **Table 1** below.

[2] Includes amphetamines, dexamphetamine/ritalin, ecstasy and methylamphetamine.
[3] MHC Treatment data extracted on 17 October 2017. Whilst the data is considered to be true and correct at the date of publication, changes in circumstances after the time of publication may impact upon the accuracy of the data.

Figure 3: Proportion of new treatment episodes by primary drug of concern (all treatment types)[4]



[4] Data missing for the Kimberley for opioids and other drugs due to small numbers (number of episodes equals less than 5).

Table 1: Proportion of new treatment episodes by primary drug of concern[5]

Year	Region	Alcohol	ATS	Cannabinoids	Opioids	Other
2012/13	State	42.4%	22.1%	17.2%	15.7%	2.6%
	Kimberley	73.6%	4.8%	19.7%	<5	<5
2013/14	State	40.7%	24.8%	17.1%	15.1%	2.4%
	Kimberley	70.5%	8.5%	18.7%	<5	<5
2014/15	State	36.9%	31.1%	16.4%	14.1%	1.6%
	Kimberley	70.3%	11.0%	17.8%	<5	<5
2015/16	State	33.0%	39.2%	14.2%	12.3%	1.3%
	Kimberley	61.9%	14.2%	23.0%	<5	<5
2016/17	State	32.7%	39.4%	14.8%	11.7%	1.3%
	Kimberley	58.3%	15.0%	24.2%	<5	<5

[5] (<5 = number of episodes equals less than five).

Data also demonstrates the disproportionate levels of harm and ill-health experienced in the Kimberley region and the impact on health services. The WA Country Health Service reports[6]:

- For the period 2011-2015 the hospitalisation rate for all Kimberley residents was significantly higher (2.0 times) than the State rate.
- For the period 2011-2015 suicide was the leading cause of death in Kimberley 15-24 year olds causing 34 deaths in the region (8.9 times the State rate).
- The rates for alcohol and tobacco-related hospitalisations were significantly higher (3.7 and 2.6 times respectively) than the State rates. Kimberley Aboriginal adult rates were significantly higher (7.1 and 5.3 times respectively) than non-Aboriginal adult rates.
- For the period 2006-2015, the mortality rate in Kimberley residents for alcohol and tobacco-related causes were significantly higher than (2.3 times and 1.6 times) the State rate.

5.2 Related projects and strategies

In addition to the development of the Plan, there has been a number of consultation processes with stakeholders and significant projects in the Kimberley that are of relevance to AOD service provision. An overview of some of these key projects are outlined below, noting that there are a significant number of projects, strategies and reports that are currently relevant to the Kimberley region, spanning across a vast number of agencies and specific target groups.

5.2.1 Methamphetamine Action Plan Taskforce

The Methamphetamine Action Plan (MAP) Taskforce recently undertook consultation in the Kimberley with key stakeholders and Aboriginal communities.

The consultation highlighted the significant community concern regarding the impact of methamphetamine in Aboriginal communities. In addition, the consultation highlighted the need to provide AOD services for people close to where they live, including access to withdrawal services and after care following treatment. The consultation also highlighted challenges associated with reducing the supply of methamphetamine and law enforcement in these communities.

The consultation also highlighted the challenges associated with regional service provision including the recruitment and retention of staff. Furthermore, the consultation raised the need for greater collaboration between service providers at the federal, state and local level.

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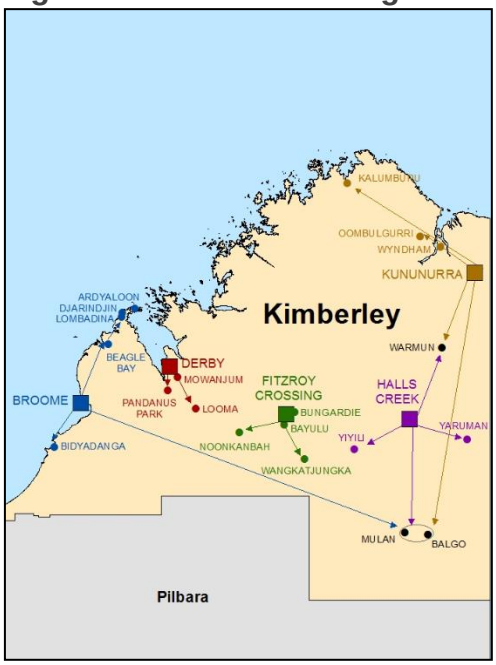
[6] WA Country Health Service 2018, Kimberley Health Profile. Accessed online 19 April 2018. Data current as of January 2018 and subject to change.

5.2.2 North West Drug and Alcohol Support Program

In 2011, Royalties for Regions funding was provided for the North West Drug and Alcohol Support Program (the Program) to reduce AOD related harm in the Kimberley, Pilbara and Midwest regions, with the Program currently funded until 30 June 2020.

In the Kimberley region, the Program has enabled the delivery of community treatment, support and prevention services which has facilitated greater outreach into remote communities where access has previously been limited or not provided. Prior to the funding support for the Program, Kimberley AOD and mental health services were primarily based in Broome and Kununurra. New service hubs have since been established in Fitzroy Crossing, Derby and Halls Creek (see **Figure 4**).

Figure 4: North West Drug and Alcohol Support hubs (Kimberley)



Given that the majority of AOD treatment and prevention services in the Kimberley are provided through the Program, securing recurrent funding is vital to ensuring service sustainability.

5.2.3 Regional Services Reform

In 2015, the State Government announced regional service reform to improve the lives of Aboriginal people in regional and remote areas in Western Australia, with a particular focus on the Kimberley and Pilbara regions.

The reform concentrates on three concerns:

- improved living conditions that enable families to prosper and don't hold them back;
- supporting families to build their skills, and overcome any barriers to doing so, through improved service redesign and delivery; and
- education, employment and housing opportunities, and support for families to take them up.

In 2016, the Resilient Families, Strong Communities: Roadmap for regional and remote Aborginal communities was released, outlining long-term Government reform to improve the lives of Aboriginal people in Western Australia, and priority actions across a number of strategic directions.

Supporting families is a key strategic direction of the reform, with the role of harmful AOD use recognised as barrier to family development.

To this end the roadmap outlined that “the State Government will provide better coordination at the regional and local-level to reduce the harmful effects of alcohol and illicit drugs on families and children in regional and remote areas.”

The roadmap also outlined that the State Government:

- will consult with and support Aboriginal communities that wish to reduce harm from alcohol; and
- will continue to support the trial and evaluation of the Cashless Debit Card in the East Kimberley.

The roadmap helped to inform an extensive consultation process, which was undertaken in the Kimberley and Pilbara regions, designed to inform the future direction of government funding and support for the State’s remote Aboriginal communities. While not exclusive to AOD, key themes across the Kimberley included:

- the importance of country and culture;
- concern with raising complaints about services for fear it would affect future service being provided to Aboriginal people in the future;
- the need for more community driven solutions for child-centred services;
- mention of successful family-centred programs, developed and implemented with community leadership;
- future aspirations to embed culture in a range of youth-based programs.
- concern about distance to services; and
- consultation fatigue and outcomes of consultation process.

5.2.4 National Ice Action Strategy 2017

In April 2015, the Commonwealth Government established a National Ice Taskforce (the Taskforce) with the objective of working with States and Territories to develop a National Ice Action Strategy (Strategy).

The final Taskforce report was released on 6 December 2015 and included 38 recommendations across five areas of priority:

- Supporting families, workers and communities;
- Prevention activities to reduce demand;
- Treatment and support services;
- Coordinated and targeted efforts to disrupt supply; and
- Data, research and regular reporting.

On 11 December 2015, the Strategy was agreed at the meeting of the Council of Australian Governments. Consistent with the findings and key actions areas outlined in the Final Report of the Taskforce, the Strategy seeks to ensure:

- families and communities have better access to information, support and tools to help them to respond to ice;
- prevention messages are targeted at high-risk populations and accurate information about ice is more accessible;
- early intervention and treatment services are better tailored to respond to ice and meet the needs of the populations they serve;
- law enforcement efforts are better targeted to disrupt the supply of ice; and
- better evidence is available to drive responses to ice.

The Commonwealth Government is providing an additional $298.2 million over four years from 1 July 2016 to support the Strategy, which includes:

- $241.5 million in additional funding for Primary Health Networks to commission further AOD treatment services to meet local need;
- $24.9 million to support communities to deliver locally-based and tailored ice prevention and education activities;
- $13 million to introduce new Medicare Benefits Schedule items for Addiction Medicine Specialists from 1 November 2016;
- $10.7 million to support clinical research into new treatment options, training of professionals and evaluating the effectiveness of clinical care for those using methamphetamines, and will include a new Centre for Clinical Excellence research body; and
- $8.1 million to improve data sources on emerging trends in drug use patterns, treatment options and early identification of new emerging drug threats.

5.2.5 Kimberley Aboriginal Primary Health Plan 2012-2015

The Kimberley Aboriginal Primary Health Plan 2012-2015 (the KAPHP) was developed in consultation with service providers in the Kimberley region, using existing planning documents, and provides recommendations for improving the design and delivery of health programmes.

The KAPHP outlines the unique challenges of service delivery in the Kimberley region which includes the population breakdown, the burden of illness, the cost of service delivery, employment issues and inequities in service delivery across the region.

The KAPHP outlines AOD as a key program area for service delivery in the Kimberley region. Planning issues identified via the KAPHP include: the inequitable distribution of services; a focus on treatment services as opposed to the spectrum of services; levels of service not meeting community demand; and planning of services not taking place with Aboriginal people within the region.

The recommendations of the KAPHP were endorsed by the Kimberley Aboriginal Health Planning Forum. The Forum has ten subcommittees including a Drug and Alcohol Committee to represent a regional view of AOD issues in the Kimberley.

Summary Points:
Based on the available information from existing strategies and projects in the Kimberley region:

- alcohol remains as the primary drug of concern for new treatment episodes in the Kimberley region, however there has been an increase in treatment for amphetamine-type substances;
- there has been a number of recent and past consultations regarding AOD service provision in the Kimberley region, as well as related projects and strategies; and
- the North West Drug and Alcohol Support Program provides funding for a large component of prevention and community treatment services in the Kimberley region.

Consultation Questions:

- ***Are there any other key strategic projects that inform the delivery of AOD services in the Kimberley region?***

6. Current service provision, gaps and opportunities

In the development of the Plan, it was recognised that people living in Western Australia, including the Kimberley region require access to AOD services across the service spectrum. The services outlined in the Plan are provided in **Table 2** below.

Table 2: Service streams of the Plan and key service elements

Service stream	Key service elements
Prevention	▪ AOD prevention
Community support	▪ AOD harm reduction and personal support ▪ AOD post residential rehabilitation (including transitional housing and support) ▪ AOD safe places for intoxicated people (also known as sobering up centres)
Community Treatment	▪ AOD community treatment services ▪ AOD rehabilitation day programs
Community Bed-based	▪ Low medical withdrawal ▪ Residential rehabilitation
Hospital Based	▪ High medical withdrawal ▪ Complex medical withdrawal

In the Kimberly region key AOD service currently provided include:

- Prevention: (provided via the five hub sites shown in **Figure 4**);
- Community Support Services: (sobering up centres located in Broome, Derby, Kununurra and Wyndham; transitional housing located in Broome and Commonwealth funded post-residential rehabilitation services in the West Kimberley);
- Community Treatment Services: (provided via the five hub sites in **Figure 4** and providing outreach to smaller communities as well as via non-government organisation providers);
- Community Bed-based Services: (residential rehabilitation located in the West Kimberley and East Kimberley); and
- Hospital-based Services: (no MHC purchased AOD services currently provided in the Kimberley region).

As outlined in **Appendix One**, current AOD services in the Kimberley region are mainly located in larger centres and provide either outreach into smaller communities; or people must travel to access services. A more detailed description regarding each of the services, how they align to the Plan modelling and any identified gaps are outlined in the sections below.

Based on the available information and in alignment with the Plan modelling, below is a summary of current service provision in the Kimberley.

Based on the available information and current service provision it is considered that:

- current levels of prevention resourcing must be maintained in the Kimberley region, recognising that ongoing funding is vital to ensure the retention of local staff.
- central support continue to be provided by the MHC to ensure that local AOD prevention activities are evidence-based and sustainable.
- options to expand the scope of services provided from sobering up centres should be explored.
- post-residential rehabilitation services need to continue to be provided on an ongoing basis.
- ongoing funding needs to be secured to continue to provide the the current level of community treatment in the Kimberley region.
- the expansion of community treatment services could enable better outreach to small communities and include the potential for additional services to be delivered, including for priority groups that have been identified via previous consultations (i.e. youth).
- the availability of low medical services including withdrawal beds outpatient services and home-based withdrawals is a prority.
- alternate models of service for residenital rehabilitation may be applicable to help people remain close to their family, friends and community such as day rehabiliation programs.
- hospital-based services (withdrawal and clinical liaison) for AOD are a clear gap.
- it is important to identify the range of services required across the spectrum to provide holistic AOD service provision for youth.
- barriers for older adults that currently exist in accessing AOD treatment be explored.
- opportunities may exist to better respond to address mental health and AOD co-morbidity.

In developing the paper, a number of priority population groups have been identified as being important for service delivery in the Kimberley region including Aboriginal people; youth; people with co-occurring mental health and AOD issues; and older adults (see Chapter 7 for more information).

6.1 Prevention Services

Current Service Provision

In 2016/17, the MHC provided funding of $20.6 million for the delivery of statewide AOD prevention and mental health promotion and mental illness prevention programs and services.[7]

Of this funding, significant investment is through the Royalties for Regions funded North West Drug and Alcohol Support Program (the Program). The Program is currently funded until 30 June 2020 and ongoing resources are vital to sustain existing prevention activities across the Kimberley region. Furthermore, the mid to long-term outcomes of prevention activities may take a number of years to come to fruition. In the absence of ongoing funding, the planning and co-ordination that has taken place to date in the Kimberley region will not be capitalised upon.

Current AOD prevention activities in the Kimberley region are focussed around the development and implementation of prevention plans including, but not limited to, Local Alcohol and Other Drug Management Plans which are supported and implemented by Local AOD Management Groups or similar groups. These prevention plans seek to enable a coordinated and collaborative approach to planning evidence-based strategies to address AOD issues that are identified by local agencies and communities. They also articulate demand, supply and harm reduction strategies that can be implemented at a local level to address AOD related harm.

The current prevention activities align with the actions outlined in the MHC's draft Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan 2018-2025 that is anticipated for release later in 2018.

Currently, dedicated prevention staff are employed in the following hub site locations:

- Broome;
- Derby;
- Fitzroy Crossing;
- Halls Creek; and
- Kununurra.

The MHC Community Support and Development Program provides high-level strategic and support advice regarding evidence-based prevention activities in the Kimberley region. Centralised support aids in ensuring program sustainability. While prevention activity across the hub sites varies across each region, activities that may be implemented under prevention plans includes:

- development and delivery of targeted AOD prevention programs, including the localisation of MHC state-wide campaigns;

[7] Mental Health Commission Annual Report 2016-17.

- delivering training to local stakeholders;
- consulting with local stakeholders to provide advice on local AOD issues;
- raising awareness of and facilitating action relating to local AOD issues of concern for example Fetal Alcohol Spectrum Disorder (FASD); and
- engaging in activities in sectors related to AOD issues (e.g. domestic violence, suicide prevention).

The MHC also provides funding to Local Drug Action Groups (LDAGs), which are a statewide network of individual community volunteers who seek to prevent and reduce AOD related harm at the local level. In addition, through the National Ice Action Strategy, funding for a Local Drug Action Team (LDAT) has been announced in Broome to prevent methamphetamine use in the community, prevent alcohol related harms and deliver support services in the Broome region.

The MHC also works closely with the School Drug Education Road Aware (SDERA) Program which provides parents and educators with skills and information to foster resilience in young people to help them make safer choices in AOD related situations. There is a dedicated SDERA officer in the Kimberley region.

In addition, the MHC has worked with a range of stakeholders and the community to provide feedback and advice regarding Section 64 and Section 175 (under the *Liquor Control Act 1988*) alcohol restrictions in the Kimberley region. These restrictions may: limit or prohibit the sale of alcohol from licensed premises; be imposed on all licensed premises within a particular area; prohibit the bringing in, possession and consumption of liquor in a declared area; and may provide for penalties to apply for people who contravene the restrictions.

Furthermore, the MHC works with local stakeholders including suicide prevention coordinators and Community Alcohol and Drug Services to reduce the incidence of suicide and suicide attempts and create mentally healthy communities in alignment with Suicide Prevention 2020 – Together We Can Save Lives.

Plan Modelling

As shown in **Table 3** below, the Plan modelling identifies that the hours of service dedicated to prevention in the Kimberley need to steadily increase in order to meet the optimal level of service required by the end of 2025.

The Plan identifies that 12,000 hours of service are required for AOD prevention activities in the Kimberley region by the end of 2025, of which approximately 7,000 are currently provided. Funding provided through the North West Alcohol and Other Drug Program currently provides the majority of this resource.

Table 3: Current resources and future demand for prevention services, Kimberley and State (‘000 hours)

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Prevention (‘000 hours)				
State	66	108	192	208
Kimberley	7	-	-	12

Gaps

Prevention activity in the Kimberley region has developed over many years, with stakeholder relationships and partnerships critical to the success of these programs.

It is noted that the sustainability of prevention activities in the Kimberley is dependent on continued funding for the North West Drug and Alcohol Support Program (via Royalties for Regions or recurrent Government appropriation). In the absence of this funding, prevention activity would likely cease and result in a signifiancant gap in meeting demand for services.

Summary points for prevention services:

Based on the available information and current service provision it is considered that:

- current levels of prevention resourcing (currently provided via the North West Drug and Alcohol Support Program until 30 June 2020) must be maintained in the Kimberley region. Ongoing funding is vital to ensure the retention of local staff and ongoing sustainabillity of prevention efforts.
- centralised support by the MHC assists in coordinating local AOD activities aligned to State planning and strategy.

Consultation questions:

- ***What are the critical factors in providing ongoing, sustained AOD prevention activity in the Kimberley region?***

6.2 Community Support Services

There are three main AOD community support services currently provided in the Kimberley region. These include: harm reduction and personal support; sobering up centres (safe places for intoxicated people); and post residential rehabilitation services (including the Transitional Housing and Support Program (THASP)).

AOD harm reduction and personal support

Current Service Provision

Harm reduction strategies are a long-standing, public health community support response for people with AOD problems. It is recognised that harm reduction strategies aim to reduce problems with continuing AOD use or relapse, without necessarily seeking to eliminate use.

In the AOD context, harm reduction strategies includes reducing the harm associated with injecting drug use (the provision of needle and syringe exchange programs), overdose prevention and/or peer education initiatives.

As shown in Table 4, there are no current estimates of hours of services dedicated to harm reduction and personal support, however this does not mean that services in this area are not being provided. For example, the Department of Health requires that all regional hospitals and health services with an accident and emergency department are required to distribute injecting equipment.[8] Harm reduction information and support may also be included in current AOD community treatment services provision.

Plan Modelling

As shown in Table 4 below, modelling for the Plan indicates that by the end of 2025, 6,000 hours of service need to be delivered per annum for harm reduction and personal support services in the Kimberley. There are no current resource estimates for AOD harm reduction and personal support in the Kimberley region.

[8] http://healthywa.wa.gov.au/Articles/N_R/Needle-and-syringe-programs-in-WA (accessed 17 July 2018).

Table 4: Current resources and future demand for harm reduction and personal support services, Kimberley and State

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Harm reduction and personal support ('000 hours)				
State	5	5	225	258
Kimberley	0	-	-	6

Gaps

The Plan modelling demonstrates that there is limited service provision dedicated to harm reduction and personal support in the Kimberley. However, it is recognised that there are statewide programs and workforce initiatives that seek to provide support to regional staff as well as embedded within other AOD community and bed-based services delivery.

Safe Places for Intoxicated People/ Sobering Up Centres

Current Service Provision

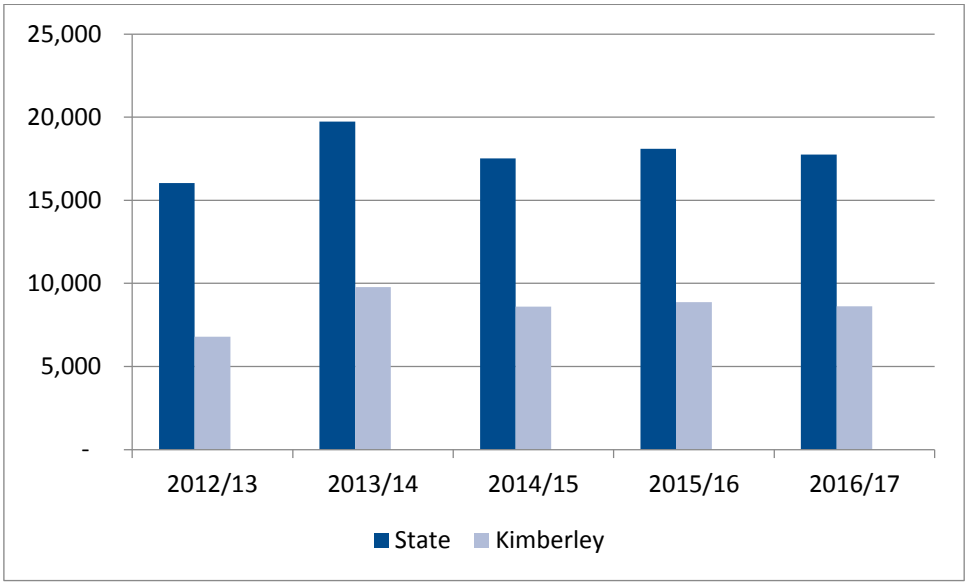
Sobering up centres (referred to in the Plan as safe places for intoxicated people) provide safe, overnight residential care where people found intoxicated in public may sober up.

Sobering up centres help to reduce the harm associated with intoxication for the individual, their families and the broader community, and play a key role in the response to family and domestic violence. People may refer themselves to a centre or be brought in by the police, a local patrol, health/welfare agencies, or other means. Attendance at a centre is voluntary. A person being cared for in a sobering up centre can expect: a safe environment, a shower, clean bed, clean clothes, and a simple nutritious meal; non-discriminatory and non-judgemental care; and referral to other agencies and services, if required.

There are currently nine sobering up centres in Western Australia. The MHC funds four sobering up centres in the Kimberley; one in each of Broome, Derby, Kununurra and Wyndham, providing a total of 91 beds at a total investment of $2,384,220 in 2017/18. The sobering up centres are open up to five days a week and operate from 3:30pm/4:00pm to 8:00am. As shown in **Figure 5** the number of sobering up centres in the Kimberley has remained stable over time. The sobering up centre episodes in the Kimberley accounted for almost half of the total episodes in the State across this time period.

There is no youth-specific sobering up services in the Kimberley.

Figure 5: Sobering Up Centre episodes, State and Kimberley.



Plan Modelling

The Plan modelling shows that AOD safe places for intoxicated people in the Kimberley region are sufficient, as the current bed numbers (91 beds) exceed the modelled demand for the end of 2025 (84 beds). There is no specific requirement for youth safe places for intoxicated identified within the Plan for the Kimberley region.

Table 5: Current resources and future demand for safe places for intoxicated people, Kimberley and State

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Safe places for intoxicated people (beds)				
State	164	178	205	205
Kimberley	91	-	-	84

Gaps

Currently, the sobering up centres in the Kimberley region only operate five days per week for limited hours and are located in the major hubs. These hours of operation may result in a greater number of problems relating to intoxication and AOD harm in the community.

It is recognised that there may be opportunities to expand the scope of services that are currently being provided from sobering up centres, to better leverage existing service provision.

In addition, the only safe places that are provided are sobering up centres. Previous consultations have raised the need to consider other forms of safe places that meet the needs of different priority population groups. These include safe places for young people, which may not necessarily be primarily based around sobering up services or bed-based services.

Post Residential Support Services

Current Service Provision

Transitional Housing and Support Program

The Transitional Housing and Support Program (THASP) provides in-reach community support for people staying in short-term accommodation following residential AOD treatment. There are currently 15 THASP houses (total of 55 beds) funded by the MHC operational across Western Australia. A 2013 evaluation of the program demonstrated a range of positive outcomes including reductions in relapse rates, improvements in wellbeing, increased life and independent living skills, and reduced levels of homelessness.

There are currently two THASP houses operating in the Kimberley (total of 8 beds). Both these houses are located in Broome at a total MHC investment of $100,300 in 2017/18. The houses are managed by Foundation Housing, a community housing organisation, and Milliya Rumurra Aboriginal Corporation is contracted by the MHC to provide the in-reach community support.

Aboriginal people account for the majority of people accessing THASP in the Kimberley region.

Post Rehab Continuing Care Service

The Post Rehab Continuing Care service is a family-based, post residential rehabilitation program (approximately 39 weeks) which provides intensive case management and recovery support following residential rehabilitation. Outreach is provided to communities to support the implementation of individual plans for people throughout the Kimberley. Milliya Rumurra has been commissioned by the WA Primary Health Alliance (WAPHA) to lead the service in partnership with Ngnowar Aerwah Aboriginal Corporation and Boab Health.

Given that the program is relatively new and the length of the program, it is anticipated that more information on the outcomes of the program will become available in due course.

Plan Modelling

As shown in **Table 6**, the Plan modelling demonstrates that 3,000 hours of service are required for post residential rehabilitation services in the Kimberley region by the end of 2025.

In the Kimberley, THASP currently provides for 8 beds in support of 40 residential rehabilitation beds (one THASP bed to five residential rehabilitation beds). In comparison to the State, the proportion is one THASP beds to approximately eight residential rehabilitation beds. As such, the Kimberley region is has a higher proportion of THASP beds compared to residential rehabilitation beds than other areas of the State. Whilst there is a requirement to continue to grow the number of THASP beds (as shown in **Table 6**) for the State, current service provision is meeting the modelled demand in the Kimberley region.

Table 6: Current resources and future demand for post residential rehabilitation services, Kimberley and State

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Post residential rehabilitation ('000 hours)				
State	12	21	41	57
Kimberley	4[9]	-	-	3

Gaps

The Post Rehab Continuing Care service commenced in 2017 and as such limited information is currently available regarding the outcomes of the program. Regardless, the program aligns to the strategic directions outline in the Plan.

The THASP is only currently funded until 30 June 2019 and ongoing funding is required to ensure the sustainability of the program. The MHC is currently exploring options for ongoing funding for the state-wide program.

It is noted that there are currently no youth specific post residential support services as a result of there being no dedicated youth AOD residential rehabilitation services (refer to Section 6.4 Community Bed-Based services). Consideration may be given to the need for post residential support services if there were to be other youth specific AOD treatment options developed into the future.

[9] The current level of service only takes into account THASP and not hours of service provided through the WAPHA Post Rehab Continuing Care Service.

Summary Points for Community Support Services:

Based on the available information and current service provision it is considered that post residential support services are meeting modelled demand in the Kimberley region. However, further consideration may be given to:

- expansion of harm reduction and personal support services;
- options to expand the scope of services provided via sobering up centres;
- options to consider the requirement for safe places for youth;
- other community support options for children and youth;
- other post residential services that may be required.

Consultation questions:

- ***How could harm reduction services be enhanced within the Kimberley region?***
- ***What other services and supports (including social and emotional well being supports) could be provided through sobering up centres to increase their effectiveness?***
- ***Is there are a requirement to consider safe places for children/young people?***
- ***Are there any further considerations for post-residential rehabilitation services in the Kimberley?***
- ***Are there other community support options required for the Kimberley region, including for co-occurring mental health?***

6.3 Community Treatment Services

Community Alcohol and Drug Services

Current Service Provision

Community AOD treatment services provide specialist outpatient services that provide one or a combination of: case management and treatment planning; brief intervention; one-on-one counselling and group work; pharmacotherapies and pain management; education, training and vocational programs; community, family and partner support; prevention services; outreach services; diversion programs and a range of social support services.

As shown in **Figure 6,** alcohol was the primary drug of concern for people living in the Kimberley region over the period 2012/13 to 2016/17. In the same period, amphetamine-type substances overtook alcohol as the primary drug of concern for community treatment episodes for State residents (**Figure 7).**

AOD community treatment services are largely delivered through the Statewide network of Community Alcohol and other Drug Services (CADS). The Kimberley Community Alcohol and Drug Services (KCADS) is based in Broome with offices in Derby, Kununurra, Fitzroy Crossing and Halls Creek, and also provides regular outreach services to outlying communities across the Kimberley region.

Funding for community treatment services in the Kimberley is largely provided through the North West Drug and Alcohol Program.

The current provider of the KCADS is the WA Country Health Service's Kimberley Mental Health and Drug Service (KMHDS) at a total investment of $3,769,971[10] in 2017/18. The service provides individuals and their families with AOD treatment and support services in the community and is free and confidential. Individuals do not require a referral and can self-refer by calling or attending the KCADS.

Services are provided for people aged 14 years and over and include:

- assessment and referral;
- counselling, case management and support;
- opiate and alcohol pharmacotherapy;
- group programs;
- support to families and significant others;
- shared care with other services;
- diversion programs for people referred by police and the courts;
- outreach counselling services; and
- support for local communities through prevention activities.

[10] Includes funding for prevention activities.

In addition, the Cyrenian House Milliya Rumurra (CHMR) Outreach Service provides AOD outreach in the West Kimberley to people living in communities along the Dampier Peninsula and as well as south of Broome to Bidyadanga (investment of $631,714 in 2017/18 funded via Royalties for Regions).

MHC also funds via a range of non-government organisations in the Kimberley to provide AOD community treatment services at a combined investment of $1,317,291 in 2017/18.

Plan Modelling

As seen in Table 7, the Plan modelling demonstrates that there is a gap in the current level of community treatment services being provided across the State as well as in the Kimberley region.

The Plan outlines that AOD services in the Kimberley, like other areas of the State, require gradual growth, which could allow for increased outreach services to more outlying areas of the region, as well as other forms of community treatment to be delivered, to an expanded range of target groups.

Table 7: Current resources and future demand for community treatment services, Kimberley and State ('000 hours)

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Community Treatment ('000 hours)				
State	565	677	1,133	2,060
Kimberley	45	-	-	72

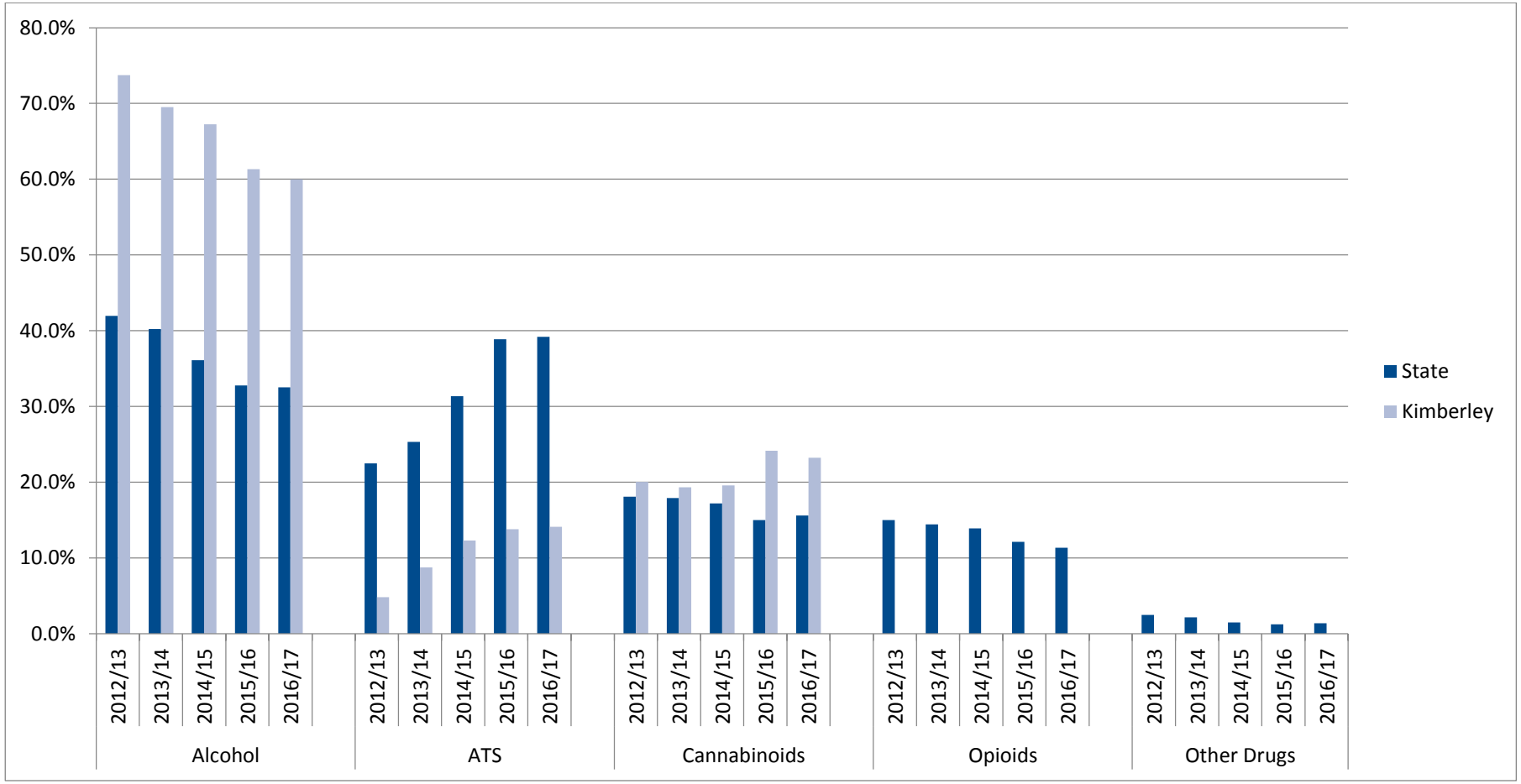
Gaps

Community treatment services are well utilised in the Kimberley, and are the main treatment accessed; however this may be a result of availability of community treatment services, and limited access to other treatment types.

As with prevention services, AOD community treatment services in the Kimberley are largely funded through the North West Drug and Alcohol and Support Program via Royalties for Regions funding until 30 June 2020. In the absence of continued funding for these positions, service delivery would be significantly reduced. This may include a reduction in the number of hub sites from which services are provided, as well as a decrease in the outreach that can be provided to surrounding communities.

Previous consultations, including the Plan consultation, have also highlighted youth as a priority target group at risk of AOD related harm. While this target group are able to access general AOD community treatment services, there are no specialist staff, funded by the MHC, dedicated to providing youth AOD services (for example, early intervention and family-based workers) for this cohort in the Kimberley. There is also limited access to specialist services for children.

Figure 6: Proportion of new community treatment episodes by primary drug of concern (Kimberley and State)[11]



[11] Data missing for the Kimberley for opioids and other drugs due to small numbers (number of episodes <5).

Alcohol and Drug Day Programs

Current Service Provision

Similar to the model of service delivered through residential rehabilitation, an alternative model of service for intensive AOD treatment intervention is through therapeutic day programs. These programs provide an alternative to residential rehabilitation services supporting an individual to remain at home during their treatment. This enables individuals to be supported by and remain close to family, friends and community, whilst accessing treatment and support services akin to those provided in a residential rehabilitation service.

The length, frequency and structure of existing day programs vary across various jurisdictions in Australia. However, as with residential rehabilitation, participants of day programs will have generally undergone withdrawal and a period of stabilisation prior to participating in day rehabilitation programs.

In the Kimberley region, day programs are currently provided at Milliya Rumurra, where clients can attend educational sessions twice a week.

Plan Modelling and Gaps

There is no specific modelling for day programs specifically outlined in the Plan, however AOD day programs would contribute to the overall total of hours of service dedicated to community treatment.

Additional, AOD day programs may provide an alternate service for those currently not accessing residential rehabilitation programs, and with stable accommodation and supports.

Summary points for community treatment:
Based on the available information and current service provision it is considered that ongoing funding needs to be secured to continue to provide the the current level of community treatment in the Kimberley region. However, it is recognised that increased community treatment could provide:

- enhanced outreach to surrounding communities;
- other forms of community treatment; and
- targeted service provision for priority target groups including young people.

Furthermore, the provision of therapeutic day programs may provide the opportunity to engage more people into intensive outpatient treatment, while still providing the opportunity to be supported by family and friends. Consideration may be given to those not currently accessing residenital rehabiliation programs and that have stable accommodation and supports.

Consultation questions:

- ***Is there a requirement to expand community treatment services to meet the needs of priority target groups, for example youth, people with co-occurring mental health and AOD issues?***
- ***Are there any special considerations in relation to services for children and young people?***
- ***Is there a cohort of people for which day therapeutic programs would be particularly suitable?***
- ***Is there any other community treatment options that should be considered?***

6.4 Community Bed-Based Services

The community bed-based services provided in the AOD sector relate to low-medical withdrawal and residential rehabilitation services. In order to facilitate smooth transition and to reduce opportunities for relapse, withdrawal is often delayed until entry into a residential rehabilitation service is confirmed and therefore the two are inter-related.

Low medical withdrawal services

Current Service Provision

Low medical withdrawal services provide 24-hour supervised AOD detoxification programs from a psychoactive drug of dependence and are staffed 24 hours a day, provide a supportive care model, and are based on non-medical or low-medical interventions with non-specialist staff. The average length of stay is five to seven days.

Low medical withdrawal beds are most appropriate when the withdrawal symptoms are likely to be low to moderate and there is lack of social support or an unstable home environment. Access to these services helps people to enter residential rehabilitation services.

Currently there are no dedicated low medical withdrawal beds available in the Kimberley.[12] Whilst withdrawal services may also be provided on an outpatient basis through a General Practitioner (GP), the current level of service is unknown.

Plan Modelling

Currently there are no dedicated AOD low medical withdrawal beds in the region; however the modelling shows a requirement for two beds by the end of 2025.

[12] Hospital-based withdrawal is required for those with more complex medical conditions in which a higher level of medical intervention is required.

Table 8: Current resources and future demand for community bed-based services (low-medical withdrawal) Kimberley and State (beds)

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Community bed-based services (low-medical withdrawal beds)				
State	17[13]	35	39	52
Kimberley	0	-	-	2

Gaps

There are currently no low medical withdrawal beds in the Kimberley however the Plan calls for two low medical withdrawal beds (refer to **Table 8**).

A lack of low medical withdrawal beds in the Kimberley can pose a significant barrier for people being able to access residential rehabilitation programs that require a person to be drug-free.

There may be a significant drop out rate between the completion of withdrawal, and commencement of residential rehabilitation treatment. This is due in part to the need to transition from one service (and location) to another. Beds co-located within existing services such as sobering up centres or residential rehabilitation services, can provide a longer assessment and stabilisation period, if required, before clients enter a residential rehabilitation program and may lead to improved completion rates.

Withdrawal services can also be provided to individuals on an outpatient or home-based basis through support from a GP and specialist staff including nursing and mental health support staff. These services do not currently operate in a formalised way in the Kimberley region.

Consideration may also be given to the co-location of low-medical withdrawal services with existing AOD services, or on an outpatient basis, which would assist in stabilising clients prior to accessing residential rehabilitation services.

[13] Includes new beds funded following the release of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

Residential Rehabilitation Services

Current Service Provision

Residential rehabilitation services offer 24-hour community bed-based residential treatment programs and intensive and structured interventions following withdrawal. Programs usually include psychological therapy, education, development of skills and peer support. The average length of stay is 13 weeks, but can range between five and 26 weeks.

There are two residential rehabilitation services in the Kimberley; Ngnowar-Aerwah in Wyndham which has 18 beds and Milliya Rumurra in Broome which also has 22 beds. These residential services are funded by the Commonwealth Government through the Commonwealth Department of the Prime Minister and Cabinet (DPMC).

Milliya Rumurra in Broome provides services for individuals, families and communities seeking to address AOD issues. The service has an Aboriginal focus however all programs can be accessed by non-Aboriginal people. The service offers the rehabilitation program and has two houses and 18 single and double bed units, with a minimum stay of 12 weeks, which can be extended.

Ngnowar Aerwah provides AOD treatment and rehabilitation programs in Wyndham, including a 13 to 19 week rehabilitation service with case management. The organisation offers a range of services, including individual AOD counselling and group work in the Wyndham community.

Plan Modelling

The number of residential rehabilitation beds available in the Kimberley region almost meets the modelled demand as shown in **Table 9**. These services are funded by the Commonwealth. However, it is recognised that current beds largely provide services for Aboriginal people and it is important to continue to meet demand for this target group through the resources currently provided by the Commonwealth.

Table 9: Current resources and future demand for community bed-based services (residential rehabilitation) Kimberley and State (beds)

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Community bed-based services (residential rehabilitation beds)				
State	442	399	558	772
Kimberley	40	-	-	44

Gaps

While the current resource is close to meeting the modelled demand for residential rehabilitation beds, it is recognised that the services primarily service Aboriginal people. It is acknowledged that there may be additional target groups who may require access to residential treatment and support, such as young people, older adults and non-Aboriginal people.

Services for methamphetamine users

There may be the opportunity to better respond to emerging issues of concern, including methamphetamine use. Evidence shows that methamphetamine users are difficult to attract and retain in treatment.[14] Ensuring that treatment is available when the individual is ready to seek help reduces individuals' and community harms that may arise if treatment is not available.

A longer stabilisation period for methamphetamine users (compared to other drugs)[15] is suitable before transitioning to residential rehabilitation. As outlined above, there are no low-medical withdrawal services available in the Kimberley region. Emerging evidence and experience is demonstrating that a longer withdrawal process and residential rehabilitation period is required for the treatment of methamphetamine users.[16] The increased number of methamphetamine users accessing residential rehabilitation and the longer periods required have increased pressures on services. This is due, in part, to the behavioural issues that can be associated with chronic methamphetamine use.

Providing these services in the Kimberley region would assist in stabilising methamphetamine users in preparation for entry to residential rehabilitation.

Data extracted from MHC databases identifies that alcohol remains the primary drug of concern for clients of community bed-based services in the Kimberley region, as shown in **Figure 8** below. The lack of availability of low medical withdrawal beds in the Kimberley region may impact the ability of people experiencing problems related to their methamphetamine use to undergo withdrawal and become stabilised prior to entering residential rehabilitation.

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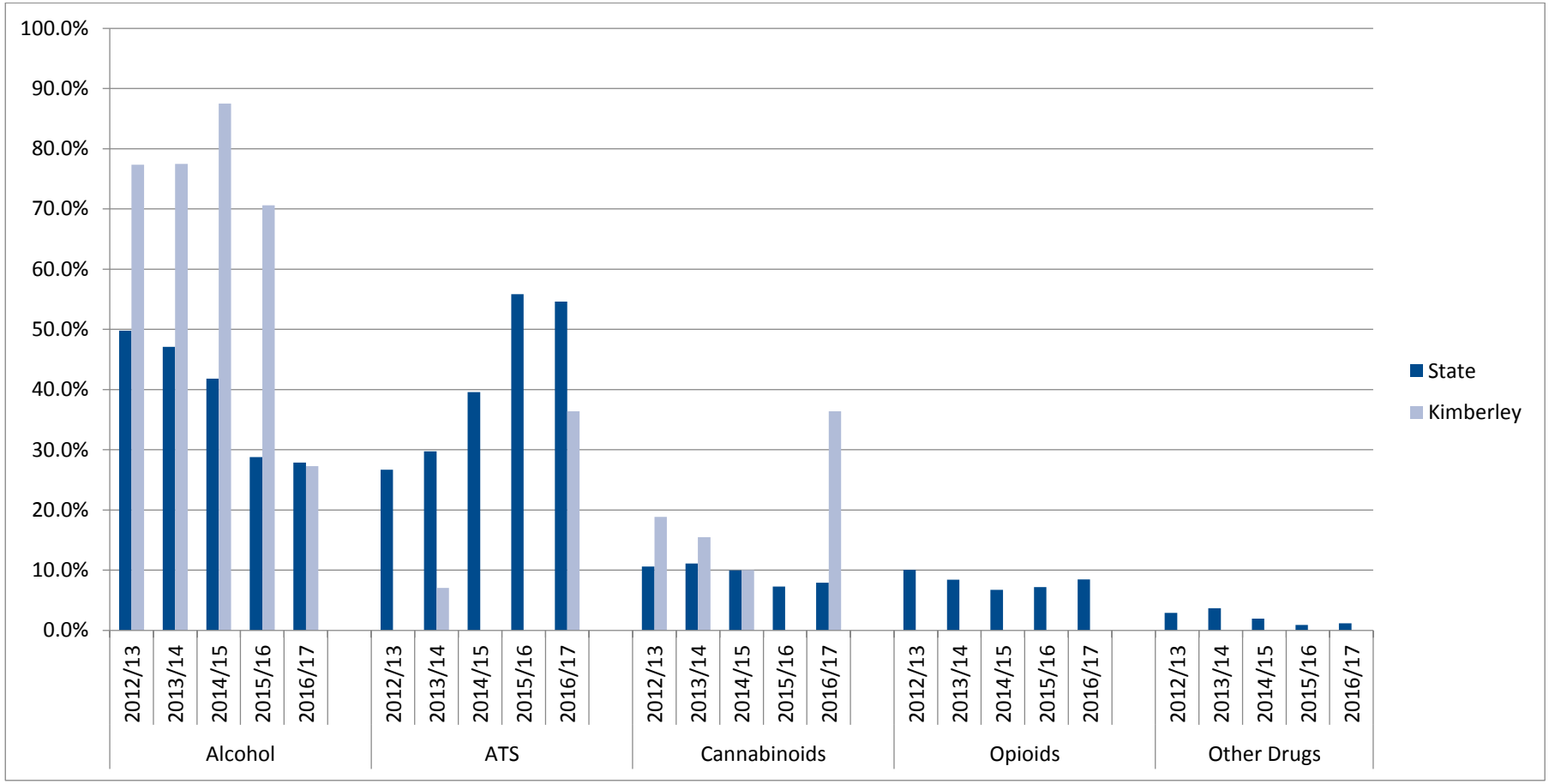
[14] NSW Health, Drug and Alcohol Treatment Guidelines, 2007, accessed 26 October 2015, <http://www.health.nsw.gov.au/mhdao/programs/da/Publications/drug-a-guidelines.pdf >
[15] Breaking the Ice in Our Community, Fact Sheet, accessed 17 July 2017, <https://adf.org.au/wp-content/uploads/2016/10/nswicewithdrawal.pdf>.
[16] Lee, N., John., L., Jenkinson, R., Johnston, J. et al. (2007) Clinical Treatment Guidelines for Alcohol and Other Drug Clinicians, No. 14, Tuning Point.

CASE STUDY – CO-LOCATION OF LOW MEDICAL WITHDRAWAL BEDS IN THE PILBARA

Although there are no low medical withdrawal beds in the Kimberley, there are two low medical withdrawal beds in the Pilbara that are co-located with the sobering up centre in Roebourne. The service is operated by Yaandina Family Centre and will accept more than two low medical withdrawal clients at a time, if possible, to utilise the other sobering up beds. The service operates as a unit for stabilising and preparing people for admission to Turner River. Clients may stay longer than the length of time usually needed to detox and is described as getting "rehab-ready". This longer stabilisation period is very suitable for methamphetamine users and almost all of the clients are successfully transitioning to rehabilitation treatment at Turner River.

Figure 8: Proportion of new treatment episodes by primary drug of concern for bed-based services[17]



[17] Data for Kimberley for opioids and other drugs (for all years); ATS (2012/13, 2014/15 and 2015/16); and cannabinoids (2015/16) is missing for due to small numbers (number of treatment episodes <5) and therefore totals do not equal 100%.

Summary points for community bed-based services:

Based on the available information and current service provision it is considered that current residential rehabilitation services align to the modelled demand in the Plan. However, gaps currently exist in relation to:

- the availability of low medical withdrawal services including beds, outpatient and home-based withdrawal; and
- residential rehabilitation services for priority target groups that have been identified via previous consultations (for example youth).

Consultation questions?

- ***Is there support for the co-location of low-medical withdrawal beds with existing AOD services in the Kimberley?***
- ***Is there are a requirement for outpatient and/or home-based withdrawal in the Kimberley?***
- ***Is there a requirement to provide residential rehabilitation beds for other target groups beyond what is currently being provided, such as youth?***
- ***Are there any other additional supports required for people in residential rehabilitation, in particular for people experiencing co-occurring mental health and AOD issues?***

6.5 Hospital Bed-based Services

High and complex medical withdrawal services

Current Service Provision

The Plan outlines that a range of inpatient withdrawal services are necessary to meet the needs of people requiring withdrawal relating to their AOD use. Dedicated beds for high and complex withdrawal would enable a short-term inpatient admission for clients with withdrawal symptoms which are moderate to severe. High and complex medical inpatient withdrawal services provide a greater level of service to address complicating medical issues, mental health issues, and those with a history of complicated withdrawals.

The Department of Health's Alcohol and other Drug Withdrawal Management Policy came into effective from 10 August 2017. The purpose of the policy is for Health Service Providers to provide access to a range of inpatient, outpatient and community based AOD withdrawal services closer to home to meet the needs of their communities.

Under this policy, relevant Health Service Providers, and Contracted Health Entities, must provide access to a range of AOD withdrawal services for their local communities, including low, high and complex medical AOD withdrawal services, either through direct service provision or referral to another service. These services can be provided in settings such as primary health care, outpatient, home, or inpatient (within a hospital or specialist AOD facility).

Hospitals in the Kimberley region which provide inpatient medical services include Broome Health Campus, Fitzroy Hospital, Derby Hospital and Halls Creek Hospital.

Plan Modelling

As shown in **Table 10**, other hospital bed-based modelled requirements in the Kimberley region include the establishment of four beds for high and complex AOD medical withdrawal (from a current base of zero beds).

Table 10: Current resources and future demand for hospital bed-based services, Kimberley and State

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Hospital based services (beds)				
State	22	33	70	98
Kimberley	0	-	-	4

Gaps

In addition to the modelled demand for four beds in the Kimberley region for hospital bed-based AOD services, (see **Table 10**) the need for hospital-based withdrawal beds in the Kimberley region was also identified in consultations on the Plan. Furthermore, health data extracted by WACHS indicates that there is 3.7 times the number of alcohol-related hospitalisations in the Kimberley region as compared to the State.[18]

In addition, while there is a mandated state-wide withdrawal policy for public health services to enable an increase in patients' access to complex medical withdrawal at public hospitals, there may be limited uptake in the absence of dedicated resourcing.

Mental health/AOD Clinical Liaison

Current Service Provision

The Plan recognises that the responsiveness of hospital emergency departments to individuals presenting with mental health AOD problems can improve through the expansion of hospital-based consultation liaison services. In addition, the Plan acknowledges that consultation and liaison teams may use telehealth services to support smaller 'satellite' hospitals to provide these services.

Consultation and liaison services in hospitals can provide information support and referral options to individuals, family members and hospital staff regarding the management of AOD issues. They can also facilitate access to treatment in the community following presentation and/or admission to hospital emergency departments to reduce the likelihood of re-admission.

[18] WA Country Health Service 2018, Kimberley Health Profile. Accessed online 19 April 2018. Data current as of January 2018 and subject to change.

Plan Modelling

As shown in **Table 11,** the Plan recognises that there are 9,000 hours of mental health, AOD clinical liaison required in the Kimberley region by the end of 2025, from a current base of no MHC funded services provided.

Table 11: Current resources and future demand for mental health, AOD clinical liaison, Kimberley and State

	Current Service Provision	Modelled Demand		
		2018	2020	2025
Hospital based consultation and liaison services (‘000 hours)				
State	218	274	292	309
Kimberley	0	-	-	9

Gaps

As shown in **Table 11,** there are no MHC funded hospital clinical liaison services currently provided in the Kimberley region. The availability of these services could also support the delivery of hospital bed-based withdrawal in the region.

Summary Points for hospital bed-based services

Based on the available evidence, there are no dedicated AOD hospital-based services in the Kimberley region for high and complex withdrawal, nor are consultation and liaison services formally provided. Therefore, consideration should be given to establishing these services.

Consultation questions?

- ***What is required to establish high and complex withdrawal and liaison services in the Kimberley region (resourcing; staffing mix; support for people accessing the service including social and emotional wellbeing)?***

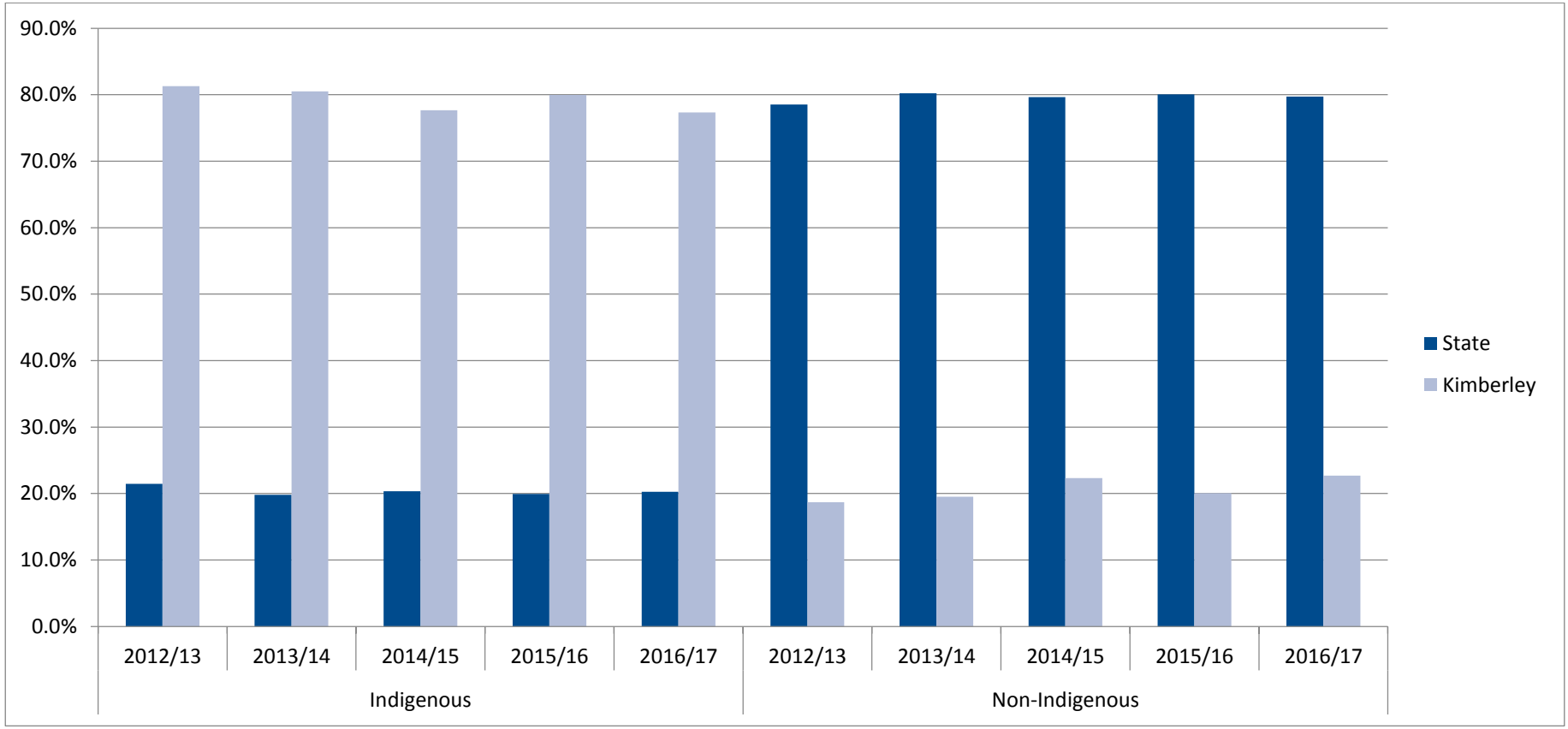
7.0 Priority Target Groups

Aboriginal people

Aboriginal people account for 41.6% of the population in the Kimberley region, as opposed to 3.1% of the total State population.[19] As shown in **Figure 9**, of the total new treatment episodes in the Kimberley from the period 2012/13 to 2016/17, over three quarters were among Aboriginal people. This compares to treatment episodes for the State where the majority of treatment episodes (approximately 80%) were among non-Aboriginal people. This highlights the need to provide culturally secure services that are inclusive of the needs of Aboriginal people and their families. It is recognised that current AOD service providers in the Kimberley are already responsive to these needs, however, there may be the opportunity to further enhance culturally secure service provision in mainstream services in the Kimberley region.

[19] ABS 2016 Census QuickStats, Kimberley (Mining and Pastoral), quickstats.censusdata.abs.gov.au, viewed 3 July 2018.

Figure 9: Proportion of new treatment episodes by Indigenous and Non-Indigenous status (State and Kimberley)



Youth

From the period 2012/13 to 2016/7 and as shown in **Figure 10**, the greatest proportion of new treatment episodes in the Kimberley health region were among people aged 30-39 years of age. This was also reflected in new treatment episodes for the State. However, this data also highlights that young people and older adults are potential target groups for tailored service provision.

Previous consultations and the environmental scan has identified that there are no AOD services in the Kimberley which specifically cater to the needs of young people. The Plan outlines that AOD services for young people in Western Australia are for those aged 12-17 years. There is currently a gap in service for high-risk young people under 14 years of age in the Kimberley region and there are risks associated with removing children from their families to access metropolitan based specialist youth services. Furthermore, it is recognised that in the case of volatile substance use, children from 10 years of age require support from specialist AOD treatment services and that existing services are not always appropriate.

As shown in **Figure 10**, people under the age of 18 years of age account for less than 10% of people accessing AOD treatment in the Kimberley region. Furthermore, data shows that for the period 2011-2015 suicide was the leading cause of death in Kimberley 15-24 year olds causing 34 deaths in the region (8.9 times the State rate).[20] It is noted that as current service provision is limited for youth this will impact on the number of treatment episodes recorded.

Through the Plan consultation, the need to investigate the establishment of youth-friendly safe places for those with AOD use and mental health issues, in regional and remote areas was identified.

Therefore, scoping of appropriate services across the service spectrum is a priority.

Older Adults

The Plan outlines that AOD services for older adults are for those aged over 65 years. Data shows that people aged 65 years and over make up 6.3% of the population of people living in the Kimberley, with the median age of people living in the Kimberley aged 32 years.[21] As also shown in **Figure 10**, people over the age of 60 years of age do not frequently access AOD services. Further exploration of this issue with current AOD service providers to identify barriers to accessing treatment for this cohort is recommended.

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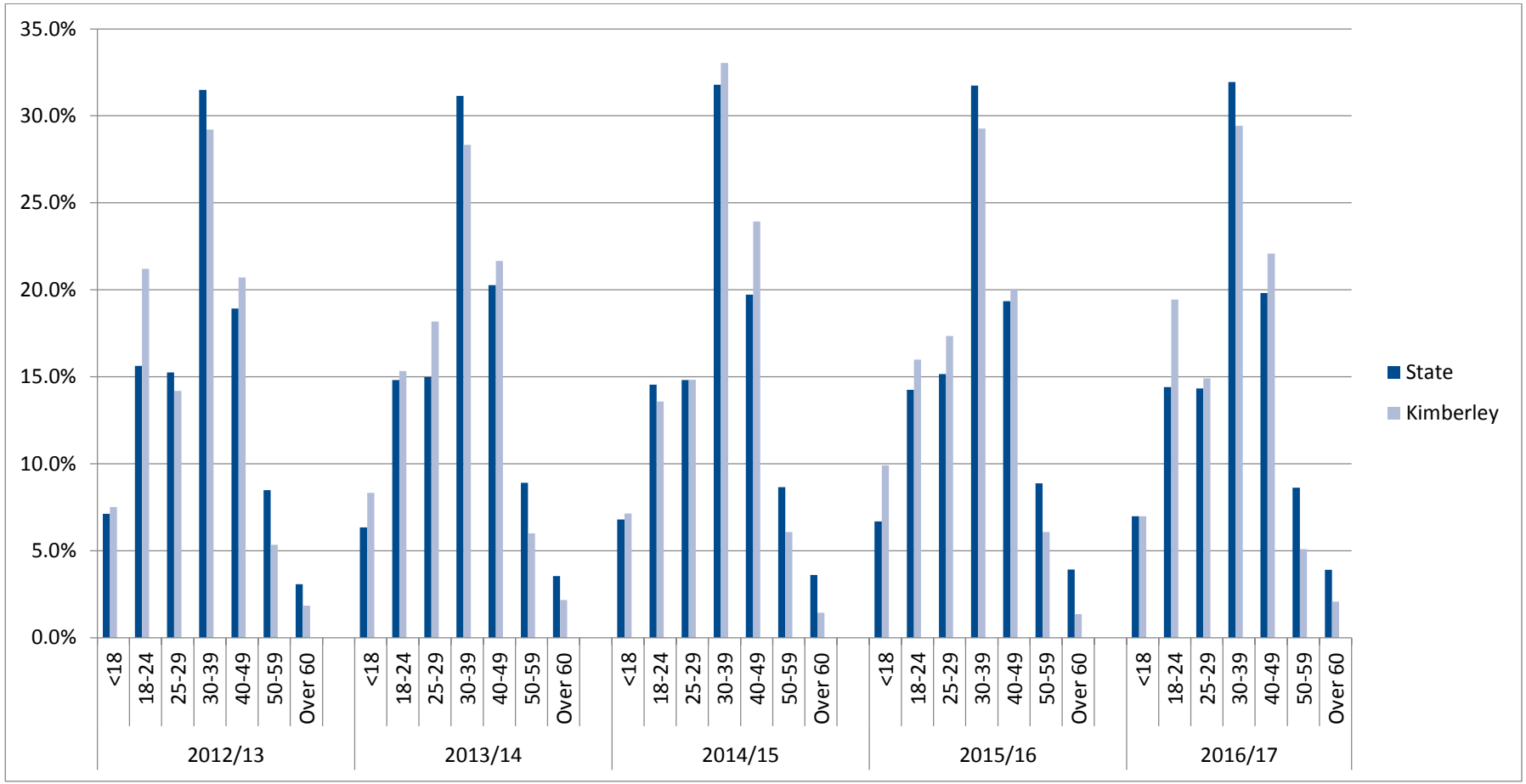
[20] WA Country Health Service 2018, Kimberley Health Profile. Accessed online 19 April 2018. Data current as of January 2018 and subject to change.
[21] ABS 2016 Census Quick Stats, Kimberley (Mining and Pastoral), viewed 3 July 2016, quickstats.censusdata.abs.gov.au, viewed 3 July 2018.

Figure 10: Proportion of new treatment episodes by age (State and Kimberley)[22]



[22] Data recorded for 'Unknown' for State residents in 2014/15, 2015/16 and 2016/17 not shown in graph due to small number (number of episodes <7).

Mental health and AOD co-morbidity

Services that are able to meet the needs of people with co-occurring AOD and mental health issues are also recognised as being a key part of service delivery.

In the Kimberley, the majority of Community Alcohol and Drug Services are provided by the WA Country Health Service's, Kimberley Mental Health and Drug Service. This provides opportunities to provide comprehensive responses to co-occurring mental health, alcohol and other drug issues.

While many AOD service providers address mental health issues as part of their core business and as part of comprehensive service provision, it is recognised that there may be opportunities to provide additional mental health supports to existing AOD services across the service spectrum.

Other considerations for service delivery

The provision of services to the Kimberley faces a range of geographical, logistical and cultural challenges. Communities are widespread; travel can be impacted by seasonal weather and road conditions.

Furthermore, services in the Kimberley are largely based in larger towns and hubs, providing outreach to smaller communities. There are a number of challenges associated with regional, remote and extremely remote service delivery in the Kimberley region, including the geographical distance between locations, as well as the sparse distribution of the population.

In addition, due to the remote nature of living and working in the Kimberley, the attraction and retention of staff can present as an issue, particularly if employment is only offered on a short-term or contract basis.

Summary points:

Based on the available information and current service provision, there is a gap in AOD services for certain age cohorts including youth and older people. Therefore, efforts are required to:

- identify the range of services required across the spectrum to provide holistic AOD service provision for youth;
- explore the barriers for older adults accessing AOD treatment;
- continue existing efforts to integrate mental health, AOD service delivery;
- continue providing culturally secure ways of working with Aboriginal people; and
- consider the difficulties of providing services in regional and remote parts of the Kimberley region, particularly outside of main service hubs.

Consultation questions?

- ***What are the range of AOD treatment and support and related services required for young people in the Kimberley region?***
- ***How can older adults better be engaged in AOD service delivery?***
- ***Are there opportunities to better integrate AOD and mental health service delivery and what is required to enable this?***
- ***What opportunities exist to provide AOD services to communities outside of the main treatment hubs in the Kimberley?***
- ***How can culturally secure service provision be maintained and further supported?***

8.0 Prioritisation of services development within the Kimberley

Based on a review of current services, previous consultations and gaps analysis, it is evident that there are opportunities to further enhance AOD services in the Kimberley region.

While prevention and community treatment services are currently within modelled limits, it is recognised that finite funding for these services places their sustainability at risk. Ongoing recurrent funding is a priority to maintain the delivery of these services within the Kimberley region.

Community support services are currently available within the Kimberley region, through the availability of transitional housing and sobering up centres. However, it is recognised that the opportunity may exist to increase the scope of services provided via sobering up centres, as well as consideration for safe places for intoxicated youth. In addition, harm reduction and personal support services also require further consideration.

A clear gap identified in the Plan consultation and evident through the modelling exists in the lack of withdrawal services. This includes outpatient, community-based (outpatient and homebased withdrawal) and within hospital settings. It is recognised that these services are critical to enable people to stabilise prior to entering residential rehabilitation, or other community treatment services, and a key priority for service expansion.

While residential rehabilitation programs are meeting the modelled demand in the Kimberley, there may be the opportunity to expand the reach of these programs to include other priority population groups. Furthermore, it is recognised that AOD day programs may provide further opportunity to provide intensive treatment, while supporting an individual to remain at home during their treatment.

Previous consultations have also prioritised youth as a key target group requiring AOD services. The lack of AOD services for high-risk youth in the Kimberley (across the spectrum of services) is identified as a priority for service enhancement. Specific consideration may be given to the further development of services that better meet the needs of those with co-occurring AOD and mental health issues.

Whilst it is recognised that sustained funding and service development is continually required across the spectrum of services, there are current gaps in services that may be prioritised for further development. A summary of the identified gaps in services is provided in **Table 12**, which highlights areas of high priority in red, medium priority in orange and lower priority in green. The level of priority has been assigned according to how close current service delivery aligns with the modelled demand, as well as based on previous consultation processes.

Table 12: Summary of gap analysis for AOD services in the Kimberley and prioritisation

SERVICE STREAM	PREVENTION	COMMUNITY SUPPORT	COMMUNITY TREATMENT	COMMUNITY BED BASED	HOSPITAL BASED SERVICES
SERVICE CATEGORIES	AOD prevention	AOD harm reduction and personal support	AOD community treatment services - Community Drug and Alcohol Services (Adult)	AOD low medical withdrawal (home based, outpatient, other)	AOD high/complex withdrawal (inpatient)
		AOD safe places for intoxicated people (Adult)	AOD community treatment services – Day Programs (Adult)	AOD residential rehabilitation (Aboriginal)	MH/AOD consultation liaison
		AOD safe places for intoxicated people (Youth)	AOD community treatment services - Day Programs (Youth)	AOD residential rehabilitation (Adult)	
		AOD post residential rehabilitation (Aboriginal)		AOD residential rehabilitation (Youth)	
		AOD post residential (Adult)			
		AOD post residential rehabilitation (Youth)			

Summary points:

Based on the available information and current service provision, the following service types (AOD) are considered high priority for service development and expansion in the Kimberley (as shown in red in **Table 12**):

- Harm reduction and personal support;
- Safe places for intoxicated people (youth);
- Post residential rehabilitation (youth);
- Community day treatment programs (youth and adult);
- Low-medical withdrawal (home-based, outpatient and other);
- Residential rehabilitation (youth);
- High/complex withdrawal (inpatient); and
- Consultation and liaison services (mental health and AOD).

Consultation questions?

- ***Based on the above information and to provide a comprehensive AOD treatment system, how would you prioritise service expansion in the Kimberley region?***

9.0 Next steps

As outlined, the MHC will use the consultation discussion paper to guide consultation and discussions regarding the optimal mix of AOD services (and co-occurring mental health) for people living in the Kimberley.

Once the face-to-face consultation and online consultation process is complete, the MHC will provide a summary of findings, including draft recommendations for service enhancement, on the MHC website for broad public comment and feedback.

Once all of the feedback has been consolidated, the MHC will use the findings to prepare a business case for consideration by the State Government as part of the 2019-20 Budget process.

APPENDIX ONE: Overview of current AOD service providers in the Kimberley

SERVICE LOCATION	AGENCY & SERVICE	FUNDING SOURCE	TREATMENT TYPES
Prevention			
Broome Derby Halls Creek Fitzroy Crossing Kununurra	MHC LDAGs WACHS SDERA	Multiple, including: MHC Royalties for Regions – North West Drug and Alcohol Support Program	Local AOD prevention strategies that seek to prevent and delay AOD related harm.
Community Support Services			
Broome	Milliya Rumurra Aboriginal Corporation	MHC	Sobering-up Centre 26 beds Open 5 days a week Operating hours 3.30pm to 8.00 am
Derby	Garl Garl Walbu Alcohol Association Aboriginal Corporation	MHC	Sobering-up Centre 21 beds Open 5 days a week Operating hours 4.00pm to 8.00 am
Kununurra	Waringarri Aboriginal Corporation	MHC	Sobering-up Centre 28 beds Open 5 days a week Operating hours 4.00pm to 8.00 am
Wyndham	Ngnowar Aerwah Aboriginal Corporation	MHC	Sobering-up Centre 16 beds Open 5 days a week Operating hours 3.30pm to 8.00 am

SERVICE LOCATION	AGENCY & SERVICE	FUNDING SOURCE	TREATMENT TYPES
Broome	Milliya Rumurra Aboriginal Corporation	MHC	THASP Housing and Service Provision Post-residential treatment support
West Kimberley East Kimberley	Milliya Rumurra Aboriginal Corporation Ngnowar Aerwah	Commonwealth (via WAPHA)	Post-rehabilitation continuing care service Specialist Aboriginal outpatient counselling and support for people exiting the residential program
Community Treatment			
Broome Derby Kununurra Halls Creek Fitzroy Crossing	Kimberley Community Alcohol and Drug Services	MHC Royalties for Regions	Provides specialist outpatient services.
West Kimberley (Dampier Peninsula and Bidyadanga)	Cyrenian House Milliya Rumurra Outreach Service	Royalties for Regions	Provides regular outreach services to outlying communities in the West Kimberley (Dampier Peninsula and Bidyadanga).
Warmum Wyndham Fitzroy Crossing	Warmun Community Inc Ngnowar Aerwah Nindilingarri Cultural Health Services	MHC	AOD community treatment services.
Community Bed-Based			
Broome	Milliya Rumurra Aboriginal Corporation	Commonwealth (DPMC)	Residential rehabilitation 22 beds
Wyndham	Ngnowar Aerwah Aboriginal Corporation	Commonwealth (DPMC)	Residential rehabilitation 18 beds

APPENDIX TWO: Summary of consultation questions

Environmental Scan:

- ***Are there any other key strategic projects that inform the delivery of AOD services in the Kimberley region?***

Prevention Services:

- ***What are the critical factors in providing ongoing, sustained AOD prevention activity in the Kimberley region?***

Community Support Services:

- ***How could harm reduction services be enhanced within the Kimberley region?***
- ***What other services and supports (including social and emotional well being supports) could be provided through sobering up centres to increase their effectiveness?***
- ***Is there are a requirement to consider safe places for children/young people?***
- ***Are there any further considerations for post-residential rehabilitation services in the Kimberley?***
- ***Are there other community support options required for the Kimberley region, including for co-occurring mental health?***

Community Treatment Services:

- ***Is there a requirement to expand community treatment services to meet the needs of priority target groups, for example youth, people with co-occurring mental health and AOD issues?***
- ***Are there any special considerations in relation to services for children and young people?***
- ***Is there a cohort of people for which day therapeutic programs would be particularly suitable?***
- ***Is there any other community treatment options that should be considered?***

Community Bed-Based Services:

- ***Is there support for the co-location of low-medical withdrawal beds with existing AOD services in the Kimberley?***
- ***Is there are a requirement for outpatient and/or home-based withdrawal in the Kimberley?***
- ***Is there a requirement to provide residential rehabilitation beds for other target groups beyond what is currently being provided, such as youth?***
- ***Are there any other additional supports required for people in residential rehabilitation, in particular for people experiencing co-occurring mental health and AOD issues?***

Hospital Bed-Based Services:

- ***What is required to establish high and complex withdrawal and liaison services in the Kimberley region (resourcing; staffing mix; support for people accessing the service including social and emotional wellbeing)?***

Priority Target Groups:

- ***What are the range of AOD treatment and support and related services required for young people in the Kimberley region?***
- ***How can older adults better be engaged in AOD service delivery?***
- ***Are there opportunities to better integrate AOD and mental health service delivery and what is required to enable this?***
- ***What opportunities exist to provide AOD services to communities outside of the main treatment hubs in the Kimberley?***
- ***How can culturally secure service provision be maintained and further supported?***

Service Prioritisation:

- ***Based on the above information and to provide a comprehensive AOD treatment system, how would you prioritise service expansion in the Kimberley region?***