Consultation summary report

Alcohol and other drug services in the Kimberley

13 December 2018

nous

Nous would like to acknowledge and thank the many committed, passionate and skilled professionals, community people and leaders in the Kimberley. We are humbled by your resilience and determination and inspired by your future goals. Thank you to those who travelled to participate in the consultations, dedicated a substantial amount of time, and offered valuable perspectives.

Contents

Glossary

Relevant terminology used in the discussion paper and this consultation summary report can be found below:

- **Capability:** The extent of someone's ability usually dependent on resources and training.
- **Capacity:** The maximum amount that a service can endure.
- **Clinical treatments:** Any treatment provided at a hospital or clinic in the community.
- **Community support services:** Services available in the community that are locally run which could include harm reduction, sobering up centres and post residential services.
- **Community treatment services:** Treatment services available in the community which may include outpatient programs, therapeutic day programs and specialised service provisions.
- **Community bed-based services**: Structured services available in the community, including residential rehabilitation and low medical withdrawal services.
- **Consultation liaison services:** A service which works in co-operation with hospital staff to provide a variety of services to patients who have both AOD related issues and mental health conditions.
- **Hospital based services**: Services that involve high and complex medical withdrawal services and are delivered in hospital settings
- **Prevention services:** Initiatives to prevent or delay the onset of alcohol and other drug use and to protect against risk and reduce harm associated with alcohol and other drug supply and use.
- **Recovery:** Recovery can be described as, "a process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential"[1].
  Recovery also involves people living a life where there is mutual exchange of contributions between the individual and their community. "A contributing life means a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty. It means opportunities for education and good health care, all without experiencing discrimination…"[2].
  It is acknowledged recovery is personal and means different things to different people. With regard to AOD use, recovery may or may not involve goals related to abstinence.
- **Youth at risk:** Young individuals who are identified as being a possible risk of harming themselves or others and who are exhibiting behavioural, situational and educational indicators.

[1] Substance Abuse and Mental Health Service Administration. (2011). SAMHSA's Working Definition of Recovery Retrieved from https://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf

[2] National Mental Health Commission. (2013). National Contributing Life Survey. Retrieved from http://www.mentalhealthcommission.gov.au/our-work/national-contributing-life-survey-project.aspx

1 Executive summary

The State Government has committed to expand specialist drug services into rural and regional areas of need including the Kimberley, as part of its Methamphetamine Action Plan 2017 election commitments. This consultation has been a key step in planning to progress this commitment into the Kimberley.

Nous Group (Nous) was engaged by the Mental Health Commission (MHC) to assist with these consultations.

In the first phase of consultation (13 August 2018 – 12 September 2018) stakeholders and organisations were invited to share their views on the current alcohol and other drug (AOD) service system in the Kimberley. One on one interviews, focus groups, workshops with consumers and their families and friends, as well as workshops with stakeholders were conducted to ensure a range of people had an opportunity to provide feedback on their experiences, ideas and hopes for the future. An Interim Consultation Summary Report was released on the MHC's website for further stakeholder feedback from 26 October – 9 November 2018. Feedback from this process has been incorporated into this final Consultation Summary Report.

Underpinning the consultations was a discussion paper developed by the MHC which provided information on the current service system and data regarding AOD use in the Kimberley. The discussion paper was posted online inviting feedback from the public by posing several specific questions. People were also invited to provide any other comments or feedback they deemed important.

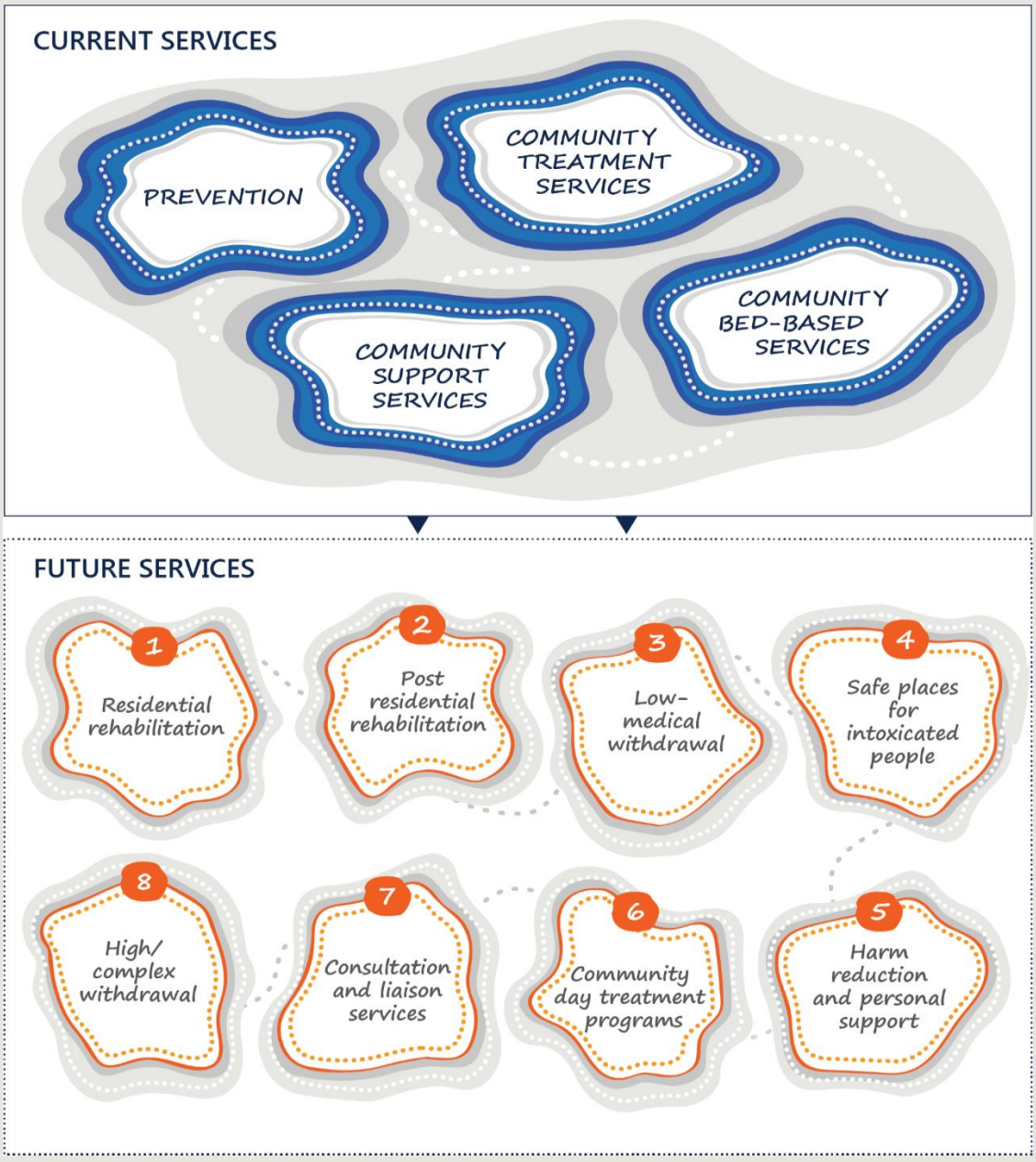
The people consulted were unanimous in what they thought were absolute priorities in any expansion of specialist drug services in the Kimberley:

- **An urgent need for prevention services to focus on youth**. The sense of urgency exists because many current prevention programs and services are not suitable for young people and because children are starting AOD use at a younger age.
- **A need for local input into the design of services so that they reflect the Kimberley specific context.** Frequent mention was made of the need for services to be locally designed and show understanding and respect for culture.
- **Better communication and cooperation between existing services**. Most contributors commented on the lack of integration between services particularly between mental health and AOD services. The results include failure to holistically support people using AOD.
- **Personnel and relationships count.** A well-designed service can only be effective if delivered by people with the right knowledge, skills and attitudes. Personnel training and re-training are therefore a key part of the introduction of expanded services.

Service prioritisation moving forward

- Stakeholders unanimously agreed that the current services; prevention, community support, community treatment and community bed-based services need to remain key areas of focus.
- While stakeholders desired current services to remain at the forefront, there was support for the future services outlined in the discussion paper. If expanding AOD services in the Kimberley, the figure below should inform the order of prioritisation of stakeholders across the region.
- Stakeholders noted that expansion of future services should be largely focussed on options for priority target groups, especially young people.

Figure 1 | A representation of service prioritisation feedback. Current services remain a priority while future services were ranked in order of importance by participants.



2 Objective

As part of the current 2017-18 State budget, funding was provided to the MHC to plan for the expansion of AOD and co-occurring mental health services in the Kimberley. The MHC developed a consultation discussion paper which provided an overview of the current services in the Kimberley region and a series of consultation questions. Nous was engaged by the MHC to undertake consultations over a four-month period to inform the development of a business case by the MHC for the consideration as part of the 2019-20 State budget process. The discussion paper topics and guiding questions were utilised by Nous to design and deliver a structured, facilitated discussion with the relevant participants to identify current service system gaps and opportunities for service improvement.

The design and delivery of the workshops and community forums that took place in the Kimberley were facilitated by Nous in partnership with Janine Dureau from Yarrjoo Nganka.

The objective of the consultations was to gain insight from Kimberley-based AOD stakeholders, community members, consumers, family members and carers to understand the inherent issues in delivering services across the Kimberley region and opportunities for service improvement. Stakeholders also included: services providers, State and Commonwealth representatives, Aboriginal Medical Services' representatives and relevant network groups. This insight and feedback given through the consultations aimed to provide further context and detail on the findings in the discussion paper and to elicit a constructive dialogue about the future of AOD services in the Kimberley.

This consultation summary report synthesises participant's commentary across all consultations and draws out key themes, ideas, issues and implications to expand the AOD services in the Kimberley. It is structured in line with the discussion paper to enable easy cross-referencing.

3 Methodology

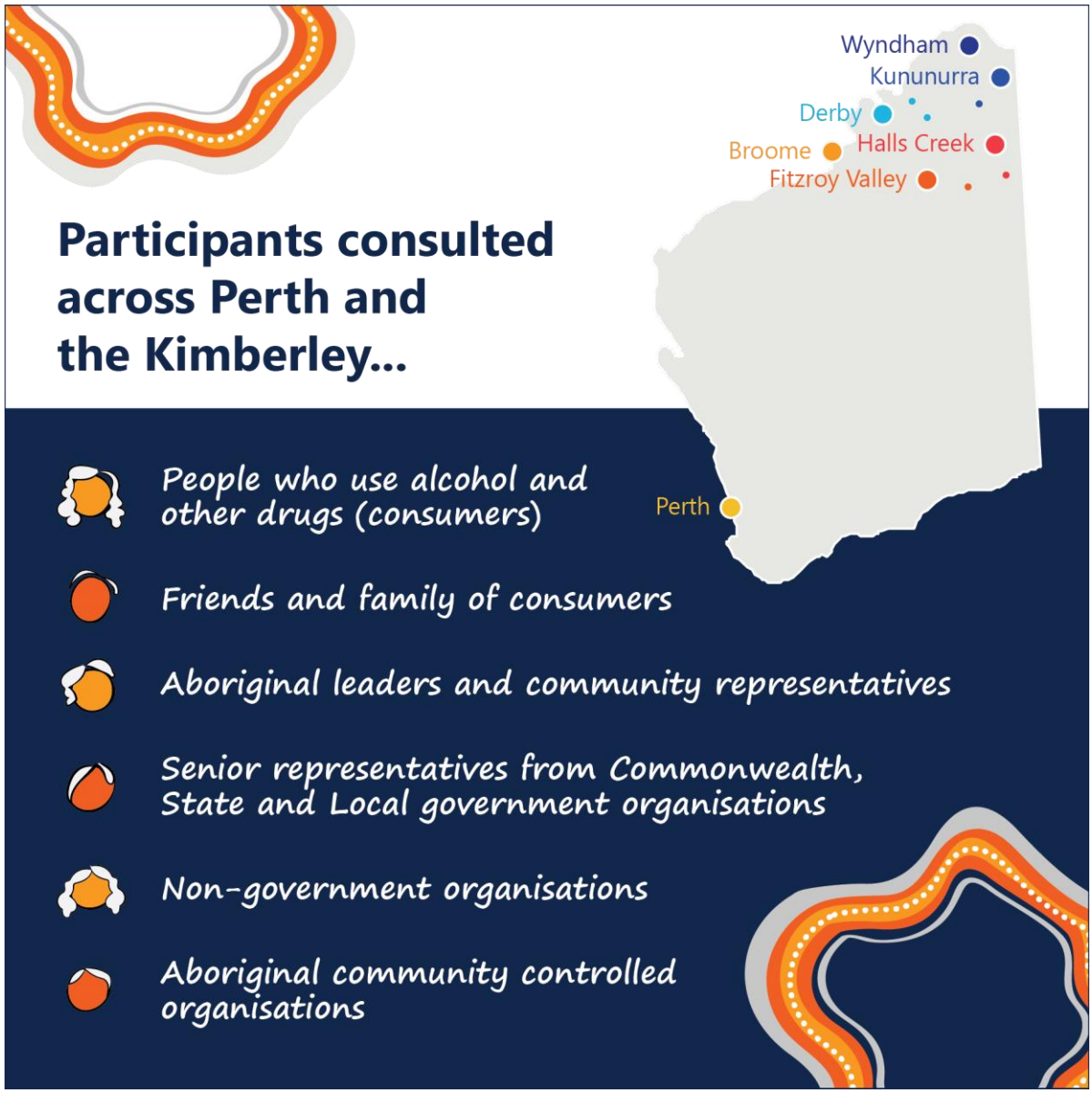
Various forms of consultation were used throughout the project, including stakeholder interviews, workshops and focus groups, community forums as well as a public online survey, to maximise engagement. There were ten stakeholder interviews across the Kimberley and five in the Perth metropolitan area, a stakeholder workshop in Broome and one in Kununurra and a consumer, carer and family workshop in Broome and one in Kununurra. There were also a small number of focus groups run with local Kimberley based groups. These consultations involved speaking to a broad range of people and organisations based in Perth, Broome, Kununurra, Halls Creek, Wyndham, Derby and Fitzroy Valley, many of whom provide services in surrounding and more remote communities. The participants consulted across Perth and the Kimberley are displayed in Figure 2 overleaf.

Discussions were grounded in the discussion paper and provided participants the opportunity to discuss their views on current AOD services and identify gaps and hopes for the future. Participants were encouraged to think boldly and provide open and honest feedback. This wide array of participants allowed for an in-depth exploration of the key discussion topics and provided helpful insights into the current state service system and identified areas of priority.

The consumer, carer and family forums set up in the Kimberley provided limited engagement and attendance. Consideration should be given to further consumer engagement regarding the development of models of service associated with current and future services. This would likely occur after funding is secured and facilitate more localised development of appropriate services.

An Interim Consultation Summary Report was released on the MHC's website for further stakeholder feedback from 26 October 2018 – 9 November 2018. Stakeholder feedback has been incorporated into this final Consultation Summary Report.

Figure 2 | Location and type of participants consulted during the consultation process



Discussions from all the consultation activities where thematically organised and analysed in writing this report. This report was released as a draft, revised by key stakeholders and participants, ensuring that the emerging themes and ideas for the future of Kimberley AOD services were the best representation of what is desired by the Kimberley community. Nous incorporated feedback into this final consultation report, and included a set of recommendations for the MHC.

4 Consideration by discussion paper chapter

This section begins with a brief overview of key themes which cut across all aspects of the consultations before exploring the specific elements of the AOD service system, as reflected in the MHC discussion paper.

For consistency, when presenting the degree of support for an idea or reflection in this report, we have used qualifiers to indicate the degree of support, as below:

- 'one participant/stakeholder' – one participant/stakeholder voiced a perspective
- 'a few' – 3-4
- 'some' – 5-8
- 'many' – 9-15
- 'most/the majority' – 15+

4.1 Cross cutting themes

It was evident that across all consultations, participants continuously identified a series of themes which are required to design and deliver an effective AOD service system. These themes are not isolated to one single aspect of the system but rather cut across many aspects on the AOD service system. Figure 3 below displays the 12 cross cutting themes, separated into principles (shown in the outer circle) and enablers (inner circle). The themes are detailed below the figure.

Figure 3 | Participants' identified principles (outer circle) and enablers (inner circle) which cut across many aspects of the AOD service system

4.1.1 Principles

Community led, co-designed initiatives deliver better results for people with AOD and mental health issues. Many stakeholders advocated that when people with lived experience are involved as equal partners in the design, development and evaluation of policies and services, it is more likely to improve outcomes for people. The majority of participants in consultations highlighted that locally led and co-designed services do not feature strongly in the current AOD service system. Some stakeholders suggested that current funding models are a barrier and do not enable co-design or community level participation or partnership within the AOD service system. This is explored further in Section 4.8.. Stakeholders acknowledged that the body of evidence is still evolving; evidence does suggest that services designed with the people who use them are more successful and sustainable. Stakeholders recognised that no "one size fits all" and that a co-designed approach to service delivery is needed. This is particularly true for Aboriginal people and was considered an important act of self-determination and healing. The majority of participants agreed that locally led and co-designed service warrants an immediate focus on community led initiatives and approaches to service design and delivery moving forward.

The AOD service system needs to be underpinned by 'whole of family' approaches to service provision. Consultation discussions frequently focussed on 'family' and 'community' service approaches as key to both prevention and recovery. AOD use impacts whole families and often the broader community; stakeholders emphasised the need for the service system to reflect this. For some families the use and impact of AOD has been over many generations resulting in family members today feeling overwhelmed, distressed and ill-equipped to manage without external support. Participants stressed that many current AOD services do not focus enough on the family system when providing services and this is a missed opportunity for community capability building and systemic long-term change. Participants also spoke about the critical role family and community members play in prevention and recovery and felt they would be better supported and more effective if they were equipped with the right information and resources.

AOD use cannot be understood without a holistic consideration of other social factors and adverse life experiences. Causal factors and other social issues and adverse life experiences occupied a large part of the conversation across all consultations. As highlighted in the discussion paper, stakeholders acknowledged the importance of a deepening understanding of trauma and co-morbidity across the region. They emphasised this should underpin the design and delivery of all AOD services. Equally, participants felt that understanding other social issues such as family and domestic violence, homelessness and long-term unemployment is critical to designing responsive, practical and effective services. Stakeholders often attributed the adverse experiences of people using AOD services to the high levels of trauma they have experienced. Stakeholders deemed AOD and mental health services sector collaboration essential for holistic treatment and support.

Stakeholders made the point that AOD services have improved their capacity and cross-sector coordination to support people with complex and co-occurring needs but noted there are still many missed opportunities to do this more consistently. Stakeholders strongly suggested that targeted investment and formalised sector development is required to establish and regulate collaborative mechanisms and measure their impact.

Integration and collaboration is key to delivering effective AOD services. Stakeholders noted that while integration across AOD services has improved, these collaborative efforts are generally formed through personal relationships and connections rather than a service system designed to encourage and incentivise collaboration. At a high level, stakeholders often referred to the need for community models and clinical services to work together in delivering local outcomes. Stakeholders also believed that the MHC can and should adopt commissioning processes which foster collaboration and integration between service providers and incentivise program outcomes through contracts.

Further, there is the need to create an effective service system, fostering collaboration and integration between AOD services rather than operating a set of discrete services.

Culturally secure services are vital to community engagement and positive treatment outcomes. Stakeholders suggested the implementation of a cultural framework or the use of cultural competency standards for service delivery as a way to enable a more appropriate service system and stronger integration with the Aboriginal-controlled service sector. Some participants shared localised culturally secure service models that had made a positive difference that could be drawn upon to develop a system-wide approach. Participants stressed that designing a more culturally secure service system requires increasing the participation of Aboriginal staff across the design and delivery of services, which in turn could help generate more community level partnerships and ongoing input from Aboriginal community leaders.

Alcohol policy reform is needed. Many participants spoke of the levers available to government which would enable positive change with regards to AOD use in the Kimberley. Most significantly was what some stakeholders described as an 'urgent need' for bolder alcohol policy reform, including liquor restrictions across the region. Many participants pointed out that there are numerous supply restrictions already in place in townships and remote communities. These restrictions do not however; cover the whole Kimberley and have inconsistent requirements between locations. Participants felt that the current situation had created some negative and unintended consequences, such as intensifying alcohol misuse by people travelling to different locations to drink. Some stakeholders were concerned about illegal supply of alcohol or 'sly grogging' and that the current design of the restrictions at a regional level created unnecessary opportunities for this to occur. Stakeholders also stressed the need for holistic service support to be provided in parallel with alcohol policy reform for optimal impact. A small number of stakeholders felt that restrictions were not the most effective approach to reduce alcohol consumption and the unintended consequences were more detrimental than alcohol use.

4.1.2 Enablers

A 'no wrong door' approach is required across the AOD and mental health service system to meet the needs of people in the Kimberley. Participants described the current system as a fragmented and rigid service system which is complex to navigate. Many participants suggested that the region could adopt a 'no wrong door policy', whereby all services would be equipped and responsible for supporting people to access the assistance they need. For example, a housing officer could provide 'warm referral' and practical assistance to support someone into an AOD or mental health service rather than sending them away to find help elsewhere. The majority of stakeholders signalled this to be the most effective way to positively enhance the current service system. They felt that careful planning and the development of mechanisms and processes to support a 'no wrong door' approach was imperative, as was building in accountability mechanisms to ensure there is appropriate oversight across the service spectrum.

Building and retaining a capable workforce in the region is crucial when improving existing service quality and expanding new services. Stakeholders noted that any service expansion means there needs to be consideration of what is required to support the current and future workforce. Participants acknowledged the commitment and hard work of staff in the AOD service system and gave numerous examples of effective and high-quality work. However, many participants stressed the specialised nature of AOD and mental health knowledge and skills and suggested more needs to be done to build the capability and capacity of workforces across the region, including growing the local Aboriginal workforce within frontline clinical roles. Specifically, stakeholders emphasised that there is a need to design training and resources to meet the specific workforce needs and operating context of the Kimberley and to provide more consistent, high quality supervision and support to frontline staff. Further, stakeholders frequently commented on the staff retention difficulties faced by government, non-government and

Aboriginal community-controlled organisations (ACCOs) for many human service professions in the Kimberley. Recruitment and retention of local and non-local staff to ensure a high quality and consistent AOD service system was considered a high priority for the majority of stakeholders, who also felt the MHC has a more substantive role in achieving this goal than it does currently.

The AOD service system needs a greater focus on community awareness and education. Many people, particularly family members of those with AOD issues, felt that basic information regarding the availability of AOD services is not readily available nor promoted in Kimberley communities. This is especially the case in regional and remote areas. People also felt there is a particular gap regarding information for methamphetamine services. Whilst methamphetamine use is not considered widespread, it is a growing community problem and not well understood. Stakeholders felt that a better understanding of the signs of AOD use and their impact would assist communities to confront AOD issues. Further to this, participants commented on the lack of awareness in communities on what services were available and what the services offered. This was apparent during the consultations with professionals and consumers and their families.

Doing the basics better, such as striking the right balance between practical psycho-social support and clinical services, was considered by stakeholders as critical to effective AOD services in the Kimberley. Many consultation participants suggested services have become unnecessarily restrained by clinical and program models, resulting in poorer outcomes. In a region as diverse as the Kimberley, services need to understand and proactively navigate the complexity of the context and be more anchored in cultural and community systems and activities.

Removing the negative stigma around AOD and mental health can help break down barriers to support and strengthen integration between services. Many stakeholders stated how prevalent the negative stigma of receiving AOD and mental health services is in the region and noted the severe impact this has on a person's willingness to engage in treatment. This consequently has negative effects on their quality of life. Unconscious bias and the attitudes of staff, as well as local communities, can also compound these barriers. A few stakeholders mentioned how the relationship between AOD and mental health services and the corrective system can contribute to this negative stigma, which must be addressed to break down the stereotypical view that these services are a mandated service. Stakeholders recognised the State and Federal Governments' priority to address AOD stigma but said there is need for a local, community-driven approach to reducing barriers to access.

Information sharing between services is a barrier to service integration and collaboration. The ability to share data between service providers was raised by stakeholders as being especially important in the context of the Kimberley. The majority of stakeholders commented that this does not work well across AOD and mental health services nor across other related sectors. Participants felt that more needs to be done to enable information sharing, and that information silos are creating unnecessary barriers to holistic approaches and integrated service delivery models, resulting in a less tailored and seamless service experience for consumers.

4.2 Environmental scan

While alcohol remains the primary drug of concern in the Kimberley region, the proportion of new treatment episodes for amphetamine-type stimulants (ATS), including methamphetamine, has tripled in the last four years. All types of stakeholders throughout the consultation period noted the increasing effects ATS are having on the Kimberley community and commented that the region is inadequately prepared to prevent, treat and support increasing ATS use. While alcohol and tobacco still remain target substances, specific planning and emphasis needs to go into services for ATS related issues.

In addition to the strategies identified in the discussion paper, stakeholders acknowledged a number of strategic projects and community leadership agendas that have a role to play in the effective delivery of AOD services in the Kimberley:

- District Leadership Groups and their outcomes framework and regional priorities plan.
- Department of Communities Strategic Reform Agenda including Kimberley service integration, Family and Domestic Violence 10-year and Kimberley Plans, Youth Strategy, Homelessness Strategy all of which seek to coordinate funding, services and initiatives through a range of partnerships, including AOD services.
- Empowered Communities Community lead reform and significantly the East Kimberley Regional Development Agenda and Family Empowerment approach in the West Kimberley.
- The Kimberley Suicide Prevention Trial led by Kimberley Aboriginal Medical Services (KAMS) in partnership with the State and Commonwealth Governments and Kimberley Primary Health Networks.
- The Kimberley Schools Project, as part of the Regional Reform work.
- Disability Services sector transition to the NDIS and review of psychosocial disability inclusion criteria.
- Fitzroy Futures driven Fetal Alcohol Spectrum Disorder (FASD) research in Fitzroy Valley.

This topic did not create or warrant a large proportion of consultation discussion, but throughout discussions on other topics, two main points were clear:

1. The impact of methamphetamines is growing faster than usage suggests.
2. Current AOD services are unevenly spread across the Kimberley, which is a disadvantage to smaller towns and remote communities.

These are discussed in turn.

4.2.1 The impact of methamphetamines is growing faster than usage suggests

A strong message from the majority of participants in response to the data presented in the discussion paper was that while ATS use is low, relative to alcohol and tobacco, the increasing use is worrying due to the significant effects the drug has on individuals, their families and their communities. Participants, especially community members warned of the extreme nature and consequences that ATS have on small, regional towns and communities.

Stakeholders also made the point that data, such as presented in the discussion paper, is often not completely accurate and lags behind the real numbers, meaning the current use of ATS is likely to be higher than reported.. Hence, there is a strong need to increase prevention and other services catered towards methamphetamines in an attempt to lower usage and respond to the consequences on

individuals, families and communities. Conversely, a small number of participants were not concerned about the rates of ATS use and felt the focus should remain on alcohol and cannabis.

Further, a few stakeholders mentioned the underrepresentation of other substances, such as volatile substances, in the discussion paper and believe they need more attention and specific prevention and treatment strategies, especially in dry communities.

"If you have a remote community with 100 people in it, and a few people are on meth, that has a huge effect on everyone"

- Peak body representative, Kimberley region

4.2.2 Current AOD services are unevenly spread across the Kimberley, which is a disadvantage to smaller towns and remote communities

Stakeholders spoke at length about the challenges of delivering AOD services in the Kimberley due to the large geographical area, diverse communities and the dispersed nature of the population. Many participants felt that there is an uneven spread of AOD services across the Kimberley, with some locations not having any locally based AOD services. Outreach services from main towns in Broome and Kununurra are highly valued by most stakeholders. Many stakeholders described outreach as an important feature of the overall service system but felt that outreach alone was not the most effective way to meet the need and demand in smaller towns and communities. It was commented that AOD investment in remote locations is best considered within the broader context of investment in human services, and due to the complexity of funding remote services, requires a strategic approach. Additionally, the annual wet season was considered a major complicating factor for smaller towns and communities as access to outreach services was further reduced during this period. Stakeholders believed that existing outreach services should be complimented by additional local services and support for community lead initiatives. Some stakeholders felt that population levels are not the best way to model for service need and that profound AOD issues in small and remote locations exist and require more focus.

Participants suggested more partnerships with health clinics and other service providers are a way to enhance the AOD service offer in remote locations. These partnerships could also create better access to patient transport to medical and low medical withdrawal services and community bed-based rehabilitation.

Suggested priorities moving forward

- Further increases in ATS use is prevented by investment in community education now.
- Data collection, reporting and modelling matures so an accurate understanding of the Kimberley can better drive planning and investment.
- Information sharing mechanisms between organisations and sectors improve.
- New partnerships between the AOD sector and other sectors are formed to improve service delivery to people with AOD issues.
- Location based funding strategies across broader human services to promote collaboration, integration and funding sustainability.

4.3 Prevention services

Prevention services are defined as any service that is provided to individuals or communities that prevents immediate or long-term AOD use.

As detailed in the discussion paper, prevention services in the Kimberley need to steadily increase to meet the optimal level of service required by the end of 2025. Almost unanimously, prevention was regarded by participants as the most critical AOD service to get right and regarded prevention as the critical AOD service for delivering positive outcomes.

Many stakeholders felt that current AOD prevention activities in the Kimberley region are too focussed around the development of prevention plans rather than investing and focussing on implementation and prevention service delivery.

Stakeholders supported the MHC's prioritisation of securing ongoing funding for the current level of prevention but felt that if ongoing prevention funding is secured through the budget process this would also present a renewed opportunity to enhance local engagement and community involvement in the development and implementation of these prevention services.

The majority of participants also made the point that Kimberley specific prevention strategies need to be anchored in day-to-day life of families and communities to have the greatest impact.

If ongoing funding is not secured, almost all stakeholders stressed that this would leave a significant gap in the service system.

When discussing prevention services across consultations, four key themes were commonly discussed:

1. AOD prevention services and strategies are the highest priority for Kimberley stakeholders.
2. The workforce and service capacity is key to any prevention strategy.
3. To ensure prevention strategies are community-driven and anchored in families, they need to be co-designed and culturally secure.
4. Prevention needs to address the underlying causes of AOD use including co-occurring mental health conditions and complex trauma.

These are discussed in turn.

4.3.1 AOD prevention services and strategies are the highest priority for Kimberley stakeholders

Building upon and improving current AOD prevention services and strategies was considered the most important priority for stakeholders. Many stakeholders commented on the need to invest in prevention rather than clinical and community treatment and strongly believe effective prevention services and strategies are the best way to deliver positive outcomes to Kimberley residents.

The importance of age and cohort specific prevention strategies is particularly relevant for the priority target groups listed in Section 4.9. Stakeholders highlighted the following areas of concern:

- The need for better education for young people on available treatment options and the approach people can take to seek help.
- More AOD education and awareness in schools and outreach services to educate at-risk youths and children who do not attend school.

- Targeted information and education for children, as a result of increasingly earlier exposure to AOD use.
- Better prevention and awareness strategies for young women, pregnant women and people with FASD.

4.3.2 The workforce and service capacity is key to any prevention strategy

The majority of stakeholders commented on the importance of having a well-skilled workforce to design and deliver culturally secure and contextually relevant prevention strategies for Kimberley people. Many participants emphasised the need to co-design prevention strategies with local people, so they are well targeted, relevant and engaging. Developing local employment pathways, particularly for Aboriginal people, was considered central to the development of a more sustainable AOD system and as a way to increase community engagement, enabling more appropriate service design and delivery.

"You can design a co-located and effective service but you will not see outcomes unless you have the staff capability to deliver"

- Service provider, Perth metropolitan

Stakeholders often remarked on the importance of continuity and consistency across the Kimberley workforce. Forming trusting relationships is fundamental to treatment and recovery processes, particularly in remote communities. Some went as far to suggest that without meaningful relationships, which can only be built over long periods of time, service provision was inconsequential. Many stakeholders felt there is more scope to imbed community and workforce engagement into clinical models, to encourage relationship building, and in turn, a more effective and collaborative workforce.

In addition, a few stakeholders referenced the small Kimberley AOD workforce, stemming from the inherent lack of supplied services, as a weakness to service delivery. Stakeholders noted the knock-on effects of a small workforce and the frequent appointment delays for people entering the service system. It was stressed that rectifying this imbalance is essential to ensuring people are never turned away from the system. A few stakeholders suggested that once people are turned away or receive delayed treatment, you are no longer preventing AOD use but rather encouraging it.

4.3.3 To ensure prevention strategies are community-driven and anchored in families, they need to be co-designed and culturally secure

Most stakeholders firmly believe that a more holistic, family-centred and culturally secure approach to prevention is required. Aboriginal stakeholders identified the need for a culturally safe service system which fosters respect, meaning and shared knowledge. Participants supported the inclusion of culturally specific service evaluations to ensure programs are culturally secure.

Participants felt that the most immediate way to achieve more culturally secure services was to involve community, especially local leaders and Elders, at every step from the design through to delivery. Connection to culture, strengthening people's sense of identity and belonging was considered central by stakeholders to the treatment and recovery from AOD use.

Principles underpinning co-design and undertaking co-design processes was singled out repeatedly as an appropriate method to design more culturally secure AOD services. Participants believed that bringing the community representatives and cultural leaders together alongside service delivery staff and AOD subject matter experts would be a transformative opportunity to the AOD service system across the Kimberley.

A few participants suggested that co-design should be mandatory and reinforced through commissioning processes.

Most Aboriginal stakeholders commented on the increased likelihood of engagement and response with prevention if community members know that local Aboriginal people were involved in service design.

Stakeholders suggested the following as potential methods of designing Kimberley-based prevention strategies:

- Community-based education co-design sessions, where people from diverse backgrounds can provide input into the system design and have access to information and other expertise.
- Improved involvement of Aboriginal people, especially community leaders, in the evaluation and design of prevention strategies and services.
- Targeted engagement with families to create prevention strategies which resonate for all.
- Sharing of information through trusted service providers to enhance collaboration.

Some stakeholders commented on the need for prevention strategies to be more creative and understanding of what drives people to AOD use. One stakeholder commented that children are turning to AOD because they are simply bored, and a prevention strategy could simply be to improve local community engagement and activities. Prevention needs to address these underlying causes of AOD use.

It was noted that integration of prevention services with other existing plans (for example suicide prevention), on a location basis could potentially remove confusion and overlap across services.

4.3.4 Prevention needs to address the underlying causes of AOD use including co-occurring mental health conditions and complex trauma

As mentioned in Section 4.1, causal factors and other social determinants occupied a large part of the conversation across all the consultation, with specific emphasis in prevention discussions. In agreement with the discussion paper, understanding complex trauma and co-morbidity across the region needs to underpin the design and delivery of prevention services. Without a clear understanding of why people are using AOD, you cannot design efficient and sustainable prevention strategies.

Many stakeholders highlighted that every area of the AOD service system needed to be trauma informed given the high and complex trauma experienced by many people accessing the AOD service system. They felt that a deeper understanding of the impact of trauma was an important prevention consideration. This requires cross-sector coordination, collaboration and integration to support people with complex and co-occurring needs. These efforts must be supported and complemented through resourcing and appropriate market design, detailed further in Section 4.

"Helping service users understand why they are using, whether it's grief, trauma or crisis is key to figuring out how to approach it now and prevent it in the future."

- Service provider, Kimberley region

Suggested priorities moving forward

- Funding for existing prevention resourcing (North West Drug and Alcohol Support Program) is secured on an ongoing basis.
- A whole-of-Kimberley Prevention Strategy is developed and resourced inclusive of localised strategies.
- A whole of community, culturally secure approach to prevention is prioritised.
- New approaches to prevention are co-designed with consumers, families and communities.
- Prevention strategies with a focus on peer support and mentoring (for youth, as well other priority target groups), play a significant role in future service expansion.

4.4 Community support services

Community support services are services available in the community that are locally run and could include harm reduction services, sobering up centres and post residential services.

The discussion paper highlights that post residential support services are currently meeting modelled demand in the Kimberley. Stakeholders were asked if they agreed with these findings and whether further focus needs to be placed on other support services such as harm reduction, sobering up centres, safe places for youth or other community support options for youth and children.

Interviews and forums focussed on the consultation discussion paper questions to elicit participants' views on the current state. In the stakeholder workshops, stakeholders were separated into small group discussions to allow for an intimate, thought provoking dialogue which reflected that this was a topic of great interest for stakeholders in the Kimberley. Discussion for community support, treatment and bed-based services was grounded in three broad questions:

- *What is currently working well?*
- *What should be done differently?*
- *What are the best hopes for the future?*

Consultation responses centred around the following four themes:

1. Current services are working well but their effectiveness is compromised due to a lack of collaboration and integration.
2. Harm reduction services need to be expanded and integrated into existing service design across the Kimberley.
3. A focus on young people, including the option for safe spaces for youth is a priority.
4. Expand access to services through sobering up centres to create new referral pathways to treatment and support

Each is discussed in turn.

4.4.1 Current services are working well but their effectiveness is compromised due to a lack of collaboration and integration

Stakeholders and participants from the various consultations acknowledged that although there are AOD community support services available, they are currently working interdependently of each other, noting this often results in people falling through the 'gaps'. Stakeholders mentioned services like the Continuing Care Model, Anglicare, Cyrenian House, Milliya Outreach Model and Sobering Up Centres, which are all providing services, are lacking the collaboration and integration required to deliver more effective outcomes. One stakeholder explained that current services work in silos: they are program centred and consequently do not support people with co-occurring AOD and mental health issues well. Stakeholders commented on the potential for community support services, specifically sobering up centres, to provide referrals to other services.

Stakeholders felt the criteria for the services were unnecessarily rigid and inflexible and consequently people were turned away from support. The lack of services available afterhours (medical and non-medical) and on weekends was seen as a major gap in the sector and compounded barriers to collaboration and integration.

It was a common suggestion amongst many stakeholders that a streamlined, integrated system which involved the collaboration and communication between services would be the most effective way to manage individual cases and prevent people from falling through gaps.

Many stakeholders focussed on building family and community capability to support young people, including the provision of training and resources to people in the community. Establishing community and peer mentors across the Kimberley was deemed an effective approach to supporting young people whilst concurrently building the capacity and resilience of the broader community.

"A no wrong door policy needs to be introduced so no-one is turned away, as soon as a person is told to come back, they will fall through the system"

- Service provider, Broome stakeholder workshop

4.4.2 Harm reduction services need to be expanded and integrated into existing service design across the Kimberley

As outlined in the discussion paper, there is currently limited harm reduction and personal support services available in the Kimberley. The consensus amongst stakeholders was that harm reduction services need to be a priority and as a first step, information and educational initiatives need to be incorporated into both school and external support programs to provide the appropriate information to both youth and adults about the long-term effects of AOD use.

The discussion paper acknowledges strategies like the provision of needle and syringe exchange programs, overdose prevention and peer education initiatives; and stakeholders agreed that these types of personal support services would be very beneficial to communities, especially for young people. Stakeholders supported the provision of a greater range of harm reduction strategies and identified that integrating harm reduction support services into existing service design would be the most effective and impactful method of service delivery.

4.4.3 A focus on young people, including the option for safe spaces is a priority

Across all consultations, a common 'call to action' was youth. Investing in support services which create safe place options and healing opportunities was identified as an urgent priority by most stakeholders. Further to this, stakeholders felt that the community and health services sectors need to focus more effort and investment in young people across the Kimberley. It was often noted that meeting the service needs of young people today is a primary way AOD use can be reduced.

It was also discussed that there is a lack of youth specific information and education regarding support and treatment options, creating an additional barrier to young people wanting access to these services.

Discussion highlighted that there are currently no safe places for young people who are exposed to severe AOD misuse, violence and other family and community stresses. Participants pointed out that young people in these situations often spend more time in public spaces or walking around townships and communities with their friends, where they can feel more in control of their personal safety and be away from their home environment.

Young people in these circumstances were also described as frequently acting out with antisocial or aggressive behaviours, more likely to meet with the criminal justice system and have entrenched AOD use, primarily cannabis. People felt that the introduction of safe spaces for youth will have an immediate impact on the consequential behaviours of AOD use.

There was a range of views about what a 'safe place' service for young people looks like, with most opinions noting, like most services, more investment would be required to properly design and deliver an effective service. A variety of 'safe place' service options were debated throughout consultations discussions. These ranged from safe place models for overnight stays only in emergency situations through to safe place models designed for medium to longer term residential support. Most stakeholders also highlighted the need to include a whole of family approach to youth safe place options including support for families when the young person is not in the home and when they return.

Some participants identified residential options 'on country', slightly removed from town, as the most appropriate and effective service option for young people. Other stakeholders articulated a need for more intensive case management services across a spectrum of programmatic options. All participants highlighted the need to co-design future options with young people, Elders and subject matter expertise and services to achieve the goal of culturally secure, trauma informed services which also address youth-specific AOD issues, and enables a restoration of a strong cultural identity and sense of belonging.

Other suggestions included the strengthening and expansion of existing services, for example Police and Community Youth Centres (PCYC), which young people are already familiar with, be made available as an option for a youth safe place.

4.4.4 Expand access to services through sobering up centres to create new referral pathways to treatment and support

Many stakeholders acknowledged the importance of sobering up centres in the overall AOD service system. A small number of participants from smaller towns and communities voiced that this was a missing essential service in these locations.

Stakeholders and participants discussed at length the requirement to expand the range of services provided through sobering up centres. It was discussed that although there are currently sobering up options in the Kimberley, service provision is limited to short-term relief rather than supported pathways to AOD and other relevant services, while some stakeholders commented that sobering up facilities do not cater for everyone, with specific reference to the lack of safe sobering up locations for women Sobering up services are not currently structured to provide more intensive longer term AOD services, however most stakeholders expressed merit in exploring this option in the future.

It was highlighted that follow-up services are essential for a more effective treatment and recovery journey for people who access current sobering up services. Participants made lots of suggestions about future service development options that could be built from the sobering up centre models.

Suggestions for the types of additional support services which could be offered inside sobering up centres include:

- referrals to services
- peer support work
- involving local councils to introduce mental health therapy sessions such as art and music
- opening shelters as 24-hour safe places for youth
- support for families involving a better case management program
- educational and activity programs, promoting harm reduction and information regarding AOD services.

Suggested priorities moving forward

- Community based services are stable and consistent through a more permanent and supported workforce.
- Key performance indicators are focussed on outcomes for people and services are more accountable to these.
- Medical and non-medical services are available afterhours and on weekends.
- Services adopt 'whole of family' approaches to AOD service delivery.
- Community based services are better integrated with each other and other sectors.
- Harm reduction educational programs are implemented in schools.

4.5 Community treatment services

Community treatment services refer to services available in the community including outpatient programs, therapeutic day programs and specialised service provisions.

Community treatment services gathered a positive response from all stakeholders across the range of consultations. The discussion paper acknowledges that ongoing funding needs to be secured to provide for continuation of the current level of community treatment services in the Kimberley region. Further, the discussion paper presents the idea of therapeutic day programs to provide opportunities to engage more people into intensive outpatient treatment. Stakeholders recognised that increased community treatment could also provide enhanced outreach services to surrounding communities and targeted service provision for priority target groups.

Responses in the stakeholder workshops and through other consultation mechanisms centred around the following three themes:

1. Community treatment services should be flexible to meet the specific needs of the Kimberley context.
2. Specialised service provision for priority target groups is desired but only if appropriately delivered.
3. There was support for a therapeutic day program option, specifically for young people.

Each is discussed in turn.

4.5.1 Community treatment services should be flexible to meet the specific needs of the Kimberley context

Participants and stakeholders acknowledged that community treatment services in the Kimberley region could be enhanced through better flexibility of services to suit the Kimberley context. Stakeholders noted that there is not a 'one-size fits all' framework for treatment options, as the social determinants of AOD issues are varied due to a range of factors affecting individuals and families in the Kimberley region. The discussion paper outlines the uneven spread of AOD services through the Kimberley with stakeholders agreeing that for smaller and remote communities this is a major barrier to community treatment services.

It was suggested that ongoing funding needs to be secured for services like outreach programs in these smaller communities so there is more availability of treatment options throughout the Kimberley region. Stakeholders identified the need for treatment options to be more family centred and involve community to assist individual recovery. It was also identified that treatment options need to include follow up services, educational awareness and recovery mentoring, including family in the process, to effectively support recovery pathways. Whilst clinical services are not considered community treatment services some stakeholders felt that community-based options could be strengthened through a stronger integration with clinical services. This could include developing more flexible treatment approaches such as the 'no wrong door' approach outlined in Section 4.1.

"Treatment services need to be person-driven, location-based and established in local conditions"

- Service provider, Kununurra stakeholder workshop

4.5.2 Specialised service provision for priority target groups is desirable but only if appropriately delivered

Participants focussed mainly on the lack of tailored services available for priority target groups, specifically youths when discussing community treatment options. Stakeholders discussed the possibility of tailored and specialised treatment services for priority target groups. Stakeholders were wary that unless services are effectively designed and delivered, meeting the themes outlined in Section 4.1, poorly delivered specialised services will be detrimental to outcomes. Inconsistent funding arrangements and current staff capability made stakeholders question whether specialised services could be appropriately implemented.

An exception to this was the need for specialised services in small and remote communities. Stakeholders identified trauma centres, youth hub services within schools, preventative health programs and counselling services as ideas for specialised treatment services that are needed within small and remote communities. It was acknowledged again, that the success of such treatment services would be heavily reliant on the funding and capability of the staff.

4.5.3 There was support for a therapeutic day program option, specifically for young people

The discussion paper's proposition on the suitability of a therapeutic day program targeted at priority cohorts provided a thought-provoking discussion in most consultations. The consensus was that therapeutic day programs were desired by most stakeholders, with initial prioritisation for a youth specific service before expanding the service to be appropriate for adults. It was suggested that a therapeutic day program could be a good option for parents who are unable to leave their children to enter into residential programs for long periods of time.

All stakeholders and participants agreed throughout the consultation process that there is a critical need for treatment options which cover both AOD and mental health related issues, specifically for youth. It was agreed unanimously that AOD use by young people is usually an escape from mental health issues and underlying trauma. Stakeholders suggested that services need to approach these co-occurring issues in a holistic way that focuses on young people's social and emotional wellbeing. It was suggested that the establishment of a therapeutic day program for youth that addresses both issues would be an efficient way of filling the current gap in the service system.

Suggested priorities moving forward

- Community treatment options are available in more locations across the Kimberley.
- Community treatment options are redesigned with Kimberley residents, services and subject matter experts to meet the specific needs of the Kimberley context.
- The idea of day programs is investigated further.
- Establish better pathways for people living in smaller townships and remote communities.
- Community treatment options are trauma informed and focus on healing

4.6 Community bed-based services

Community bed-based services are structured services available in the community, including residential rehabilitation and low medical withdrawal services. The discussion paper presented a range of information on current service capacity and modelled demand for the future.

The discussion paper states that the current residential rehabilitation services align to modelled demand. There are however current gaps in the availability of low medical withdrawal beds, outpatient and home-withdrawal and residential rehabilitation services for some priority target groups. To encourage a future focussed discussion, participants were prompted with questions around: co-locating low-medical withdrawal beds within existing AOD services; establishing outpatient and home-based withdrawal; establishing residential rehabilitation beds for youth and if additional supports were required for residential rehabilitation for people with co-occurring mental health issues.

Responses in the consultations were captured in the following three key topics:

1. Current services are working reasonably well but they need to continually develop and expand to be effective
2. Co-location of low-medical withdrawal beds within existing AOD services would provide a comprehensive treatment pathway and integration of services
3. Residential rehabilitation for youth was largely desired by stakeholders

Each of these is discussed in turn.

4.6.1 Current services are working reasonably well but they need to continually develop and expand to be effective

Stakeholders acknowledged that the current community bed-based services are working reasonably well but they require capable staff, resources and continual funding to continue to provide effective services for the community. The discussion elicited thoughtful and engaging dialogue about the current service system and stakeholders provided valuable insights into existing gaps. It was suggested that a deeper understanding into residents' ability to access these facilities be undertaken to better understand current state of services. It was discussed that community bed-based services may not always be suitable for everyone. For example, particularly those with employment or family responsibilities. There were mixed views regarding home-based and outpatient withdrawal options. With regards to home-based withdrawal options, participants felt that this could benefit a small number of people in the Kimberley, particularly if transport is a barrier. Stakeholders speculated that this may already be occurring to some degree with support from General Practitioners (GP) and other health services and this option could be better promoted by GP where appropriate. Most stakeholders stressed that home-based withdrawal would not be effective for many people using AOD in the region due to insecure housing and overcrowding, and unsupportive home environments. This is particularly relevant where other adults are using AOD in the home.

Stakeholders also commented that current services predominantly focus on crisis cases, stating that outside residential rehabilitation there are limited detoxification and withdrawal facilities available to the community. Stakeholders called out the need for treatment options prior to 'crisis point', enabling more people to receive detoxification and withdrawal services.

Overall, it was concluded that there are still large gaps in the availability of low-medical withdrawal beds, and residential rehabilitation services and withdrawal services for youth.

4.6.2 Co-location of low-medical withdrawal beds within existing AOD services would provide a comprehensive treatment pathway and integration of services

Most stakeholders expressed their dissatisfaction with current withdrawal options. Participants identified the transition point from detoxification withdrawal to residential rehabilitation as a gap in the current system. The current situation was described as a 'catch 22' whereby individuals needed to be 'drug and alcohol free' to meet the criteria for safe admission into residential rehabilitation. In many cases a period of supported withdrawal would be required to meet this criterion. The level of support varies from person to person with only a small number of people with high and complex health issues and/or where the withdrawal would present significant health risks. Establishing low-medical withdrawal beds within existing services could be an effective conduit for individuals to access residential rehabilitation services or other community-based services.

While generally supportive of the co-location of services, most participants acknowledged that co-locating low-medical withdrawal beds would require the AOD service sector to build new skills, capability and cross sector partnerships, which would require support and investment. Overwhelmingly, people felt that the current AOD services were well placed to expand into this area.

4.6.3 Residential rehabilitation for youth was largely desired by stakeholders

The discussion paper outlined that there are currently two residential rehabilitation services which offer 24-hour community bed-based treatment programs in the Kimberley; one in Wyndham and one in Broome which have 18 and 22 beds, respectively. Both of these rehabilitation services were acknowledged by stakeholders as working well, but they identified that there are no options for residential rehabilitation for youth. The idea of a residential rehabilitation for youth was well supported by participants who suggested that a service like that would be very beneficial in the Kimberley region, especially one including additional supports for co-occurring mental health issues. Stakeholders believed there is additional benefit from implementing residential rehabilitation for youths as this provides an opportunity to work with the family of the young person receiving treatment and support change at home to foster a more supportive environment. Stakeholders also commented on the positives of implementing on-country community rehabilitation programs, as a mechanism to enable young people to rebuild cultural identity and strength. There is a large requirement for services to address the underlying causes of AOD use amongst youth and stakeholders agreed that there needs to be a large investment in youth mental health.

"Youth are slipping through the cracks, nothing will change unless there is an investment in youth issues relating to mental health"

- Online submission, MHC Website

Suggested priorities moving forward

- Develop comprehensive residential rehabilitation for young people which includes withdrawal, appropriate community supports (including on-country programs) and that take into account the need to work with families.
- Low-medical withdrawal beds are co-located with existing bed-based services.
- Health clinics in remote communities are delivering low medical withdrawal.
- Individuals who want to opt for a home-based withdrawal have the option to do so.
- 'Respite' options for patients transitioning from withdrawal to bed-based treatment are available.
- More post rehabilitation services are established including 'time out and respite' services.
- Community bed-based services have a stronger focus on social and emotional well-being.

4.7 Hospital based services

Hospital based services are those that involve high and complex medical withdrawal services and are delivered in hospital settings.

The discussion paper recognises that there are currently no dedicated AOD hospital based services in the Kimberley region for high and complex withdrawal nor is there any formal consultation liaison services. Stakeholders were asked whether they believed the Kimberley needed to prioritise investing in these services and if so, what would be required in establishing these services. It was noted that the current success of hospital based services across the region is strongly tied to bed availability.

Discussions often centred around topics and issues stakeholders were passionate about or what they considered the priorities for the Kimberley. Whilst people spoke about hospital based services in many of the interviews, focus groups and workshops, it was not a topic stakeholders focussed most attention on. Most stakeholders agreed that the inclusion of hospital based services is an essential element of the AOD service system; however, it is not a priority area for expansion, while some stakeholders questioned whether these services could be effective at all.

Due to the size of the Kimberley, a few stakeholders suggested that if there were four beds for high and complex withdrawal, as modelled in the discussion paper, that these beds need to be distributed based on current need throughout the region to promote more equitable service delivery.

Consultation discussion centred around the following three points:

1. High and complex medical withdrawal services and formal consultation and liaison services are desired but deemed not a priority by stakeholders.
2. If hospital based services are expanded, investment in hospital capability would be required.
3. Service users' transition back into the community is key to successful recovery.

Each of these is discussed in turn.

4.7.1 High and complex medical withdrawal services are desired but deemed not a priority by stakeholders

Discussions with stakeholders exposed a broad range of views on the priority and effectiveness of hospital based services. Most expressed that while investing in dedicated hospital withdrawal beds was not a high priority, everyone agreed that there is a small number of people who require hospital based services and that they should be able to access these services if needed. Stakeholders from smaller townships noted that hospital based options are a good option in the absence of other approaches and assist people with co-occurring issues, including mental and physical health.

Most stakeholders concluded that low medical withdrawal services are much more pressing and relevant for Kimberley people, and are more effective.

4.7.2 If hospital based services are expanded, investment in hospital capability would be required

Like most service expansion discussions throughout the consultations, service providers emphasised the importance of co-design, quality and consumer experience. Many stakeholders said that current arrangements in hospitals for people requiring AOD related health support, including medical withdrawal, were not as robust as they need to be. Stakeholders acknowledged that medical staff often have competing priorities and are managing unpredictable priorities. However, they also stressed that people with AOD issues have specific support needs which often get overlooked due to a lack of understanding and knowledge. A few participants said that attitudes and beliefs of some hospital staff towards people who use AOD was negative and judgemental, pointing out that people who use AOD were reluctant to access hospital services if they have had a bad experience previously. Training hospital staff in AOD specific knowledge and skills was considered central to any future expansion efforts.

Due to the low numbers of potential users and the diversely spread population, one stakeholder suggested that the most effective implementation of this service would be the inclusion of one bed at each of the inpatient medical service hospitals: Broome Health Campus, Fitzroy Hospital, Derby Hospital and Halls Creek Hospital, rather than multiple beds in one location.

4.7.3 Formal consultation and liaison services are desired by stakeholders

Consultation and liaison services involve a co-morbidity service which works in co-operation with hospital staff to provide a variety of services to patients who have both AOD related issues and mental health conditions. These services can work effectively in hospitals providing assessment, referral and support for patients who need to be treated for both mental health and AOD related issues.

While high and complex medical withdrawal services did not gather much attention from stakeholders, there was strong support across consultations and the online submissions for the inclusion of formalised consultation liaison services within hospital settings. It was frequently stated by stakeholders that in most cases, AOD and mental health issues are co-occurring to varying degrees; therefore, this type of service would be very effective in hospital settings across the region.

4.7.4 Service users' transition back into the community is key to successful recovery

The stakeholders who deemed the expansion of hospital based services is not a priority, talked at length about the disconnection from family and community people experienced during hospitalisation, highlighting the added challenges people face when transitioning back to community. Significantly stakeholders stressed that better coordination and planning was required upon discharge for people to continue their treatment and recovery in the community. If the service system in the Kimberley is to include hospital based withdrawal services, the environment must be conducive to effective transition for individuals back to community and upon discharge provide access to community based AOD services.

"Better connections and resourcing between hospitals and community services is needed –hospitals are not operating in this space at all"

- Online submission

Participants included ideas such as stronger more formalised linkages with service providers so individuals can continue to receive services in community and formalised follow-up arrangements to ensure individuals are receiving an appropriate amount of support when they're back in community.

Suggested priorities moving forward

- Prioritisation is given to prevention not hospital based services.
- Hospital based withdrawal beds are distributed across Kimberley locations, according to need.
- Hospitals have the resources to deliver the service consistently and at a high quality.
- While not a priority, formalised consultation and liaison services are imbedded within hospitals.
- There are specialist AOD and mental health staff in hospitals.
- Post discharge, follow up services are available to consumers and their family.

4.8 Market design and funding arrangements

Although not a discussion paper topic, market design and funding arrangements gathered a large amount of input across all types of stakeholder consultations. Unsurprisingly, conversations centred around the influence of funding and policy arrangements in creating an equitable, integrated and collaborative service system. It is clear that stakeholders believe there are opportunities to alter the market design and funding arrangements in the future to improve service delivery across the Kimberley.

Key themes from these discussions were:

1. The funding and policy environment should enable co-design, service integration and collaboration while incentivising the delivery of outcomes.
2. The current funding fragmentation complicates delivery.
3. Funding needs to be better tailored to the Kimberley context.
4. The establishment of a regional partnership and decision-making mechanism would support better outcomes for people in the Kimberley.

Each of these is discussed in turn.

4.8.1 The funding and policy environment should encourage integration and collaboration while incentivising the delivery of outcomes

As outlined in Section 4.1, a consistent theme throughout all discussions and covering all discussion paper topics is the need to better integrate service delivery and promote collaboration to deliver tailored outcomes. A few stakeholders across the interviews and in the workshops stated that the current funding arrangements creates competition, rather than fostering a collaborate service system. Many stakeholders believed that policy and funding processes need to enable this outcome. Most stakeholders expressed that service integration and collaboration enables better support and treatment outcomes; however, it does not and will not occur adequately unless properly resourced and designed.

A few stakeholders supported the idea of more work and collaboration with local drug action groups is key to delivering outcomes.

Stakeholders identified mechanisms such as co-commissioning and incentivising positive outcomes in contracts warrants further exploration.

"The right funding environment can break down the artificial barrier between AOD and mental health and encourage integrated service delivery"

- Service provider, Kimberley region

4.8.2 The current funding fragmentation complicates delivery

A strong message across consultations was the complicating effect of fragmented funding on service delivery, with specific reference to the fragmentation of State and Commonwealth funding. Stakeholders noted the importance of coordinating funding between State and Commonwealth Governments, stating that complications in funding and tender processes often make it difficult for local service providers to gain funds for service delivery. Furthermore, representatives of ACCOs and NGOs in the region stated there is uncertainty around the distribution of Commonwealth funds, creating a difficult-to-navigate and inefficient system.

Service providers are seeking clarity around the supply of funding as this needs to be fully understood to match and cater for service demand. A few participants commented on the positives of clear, longer term contracts and the follow-on incentives to develop a skilled and sustainable workforce, ultimately providing better outcomes in the region. Stakeholders commonly referred to the current system as being filled with red tape and as a result, constraining service providers from delivering the best possible outcomes for Kimberley residents.

While many stakeholders believe the funding arrangements could be constructively altered to enable an equitable and fair distribution of funds, some suggested a complete reform, stating the need to start from first principles and tailor arrangements to Kimberley specific outcomes.

"If we keep putting in the same inputs we're going to keep getting the same outcomes, it needs a shake-up"

- Service provider, Perth

4.8.3 Funding needs to be better tailored to the Kimberley context

Throughout consultations, many stakeholders were persistent on the need for local enterprise and industry to drive outcomes in the region, with an enabling relationship with government. Stakeholders see the government and the MHC in an enabling role, as policy and regulation providers and commissioning agencies rather than service delivery agencies. Stakeholders believe a more devolved approach to funding, potentially through a local partnership team, will allow for a more tailored and suitable environment for service providers.

Stakeholders commonly mentioned the disconnect between the funding environment and the Kimberley context, stating there is the need to move from a responsive funding culture to a more pragmatic and forward looking funding culture. Many stakeholders believed devolved and local funding decisions could alleviate the political environment's effect on Kimberley funding arrangements and present opportunities to design a market which better meets local needs, especially in smaller towns and remote communities.

4.8.4 The establishment of a regional partnership and decision-making mechanism would support better outcomes for people in the Kimberley

Many discussions grappled with how to bring all levels of government and Aboriginal leadership together at a regional or sub regional level to address social issues and unlock the potential of the region. Many people favoured the idea of establishing a formalised regional partnership and decision-making mechanism comprised of all levels of government, community-based services and local Aboriginal leadership, optimally representative from in and outside of the region.

This mechanism could enable a joined-up leadership approach to a range of issues impacting on people in the Kimberley including AOD use. A regional partnership and decision-making mechanism could routinely and accurately identify local investment priorities and support the co-design of services. Developing this sort of mechanism was considered necessary structural reform if current investment in the region is to support better outcomes for people across the region.

Suggested priorities moving forward

- New commissioning models are explored including co-commissioning models between State and Commonwealth Governments in partnerships with local leaders aligned to local priorities.
- Delivering measurable outcomes are incentivised through contracts.
- Establishing a regional partnership and decision-making mechanism is supported and investment is made in its design.

4.9 Priority target groups

Priority target groups in this context are specific groups of individuals who are deemed as being the most in need of AOD and mental health services.

Recognised by the discussion paper, there are current AOD service provision gaps for certain cohorts across the Kimberley. The discussion paper mentions the need to increase efforts to provide holistic AOD services for youths, address barriers for older adults accessing AOD treatment, continue to integrate mental health and AOD service delivery, continue to provide and improve culturally secure ways of working with Aboriginal people and the need to address difficulties of providing services in regional and remote parts of the Kimberley. Stakeholders mostly agreed with these priority target groups while including additional groups, adding more specificity and identifying mechanisms to improve service delivery to these groups.

While the need to focus on certain groups of people to provide targeted services was almost unanimous, one stakeholder stated that providing specific services to specific cohorts is not ideal, as it tells the communities that only these groups of people have these problems. This can potentially inhibit other individuals from accessing services. When prioritising and targeting services to groups of people, it is evident there is the need to still be inclusive of all people in the Kimberley and ensure services are inclusive to the diverse Kimberley population.

The priority target groups identified by stakeholders can be seen in the Figure 4 below.

Figure 4 | Priority target groups identified during the consultation process

It is important to note that some individuals fall into more than one of these priority groups. In no particular order, a description of consultation feedback and justification for prioritising these specific cohorts is below:

Pregnant women

Many participants expressed their deep concerns about the level of alcohol use by women when pregnant. They were concerned about both the unborn child and the lifelong impact of FASD as well as the mothers, particularly those with long term AOD issues. Stakeholders acknowledged work has been done across the region to increase community awareness but stressed the AOD service system needs to focus heavily on education about the effects of AOD and preventing women, in particular young women, from AOD use. Some participants suggested specialist community bed-based treatment services should be available for pregnant women using AOD.

People with FASD

FASD was a large focus throughout all consultation discussions. Many stakeholders pointed out that there are now three generations of people with FASD presenting profound challenges to individuals, families and communities. Understanding FASD, its impact, and how to best support people with FASD was deemed fundamental to a successful AOD system in the Kimberley. Stakeholders felt that the vulnerabilities of people with FASD were not well understood, nor integrated into service design across the continuum of AOD services nor at service integration points between AOD and mental health.

In tackling FASD, stakeholders often mentioned the Marulu - The Lililwan Project in Fitzroy as a foundation to build upon. Stakeholders highlighted repeatedly that the success of this program was because it was community led and designed with services. As detailed previously in Section 4.1, co-designing services with community is required to deliver effective outcomes.

Young people

Stakeholders echoed the discussion paper's views on the lack of youth-specific AOD services in the Kimberley, with the majority of stakeholders supporting safe places for young people with AOD use and mental health issues. Participants throughout consultations stressed the importance of AOD and mental health services that specifically focussed on young people across the continuum of AOD services and that this focus was the key to turning the tide on escalating AOD use. Equally, participants underlined the need to support and resource community level support networks, initiatives and strategies alongside service pathways. One stakeholder even went as far as to say that young people should be at the centre of all services in the region, integrated within whole of family interventions.

A particular area of concern for young people is the lack of awareness and education around the consequences of AOD use. Further, while there are currently no youth-specific services, there is a poor understanding of AOD and mental health services available to individuals, particularly in smaller townships and remote communities. This results in low engagement with the system. To compound this issue further, the negative stigma around AOD and mental health services is resulting in many young people not receiving the services they need due to negative perceptions of services. There is the need to break down this barrier, especially for young people.

Many participants noted the need for an increase in the number of young AOD and mental health staff, as young people do not take advice from people they cannot relate to. This links to Section 4.1 and the need to build and retain a more effective workforce, in the most appropriate way for service users.

Children and young people at risk

Vulnerable and at-risk children and young people across the region were singled out as a particular group that required urgent and specific focus. This includes young individuals who are identified as being a possible risk to harming themselves or others and who are exhibiting behavioural, situational and educational indicators.

Participants acknowledged that there are a number of existing inter-agency mechanisms in place to coordinate services and case management for children and young people who have been identified as high risk. Many stakeholders felt that this approach would also be a useful approach to prevention and an effective mechanism to provide support for the family and young person holistically.

The educational, social and community benefits of regular school attendance are inaccessible to young people in these circumstances which further compounds their adverse life circumstances and limits future opportunities. These social issues and other determinants compound the effects of AOD use across the spectrum of young people.

Stakeholders made the comment that the system needs to understand that the range of young AOD users now includes children as young as six and ensure the workforce and services are versed in the required skills to deliver appropriate services to this cohort Further, there is a large proportion of children and youth in the region who are not attending school, meaning they are not receiving any AOD or mental health education. The need to outreach education into communities, especially regional and remote, is pressing.

"When we say young people now, we're not talking teenagers, this encompasses children from six to 12"

- Service provider, Broome stakeholder workshop

People with co-occurring and complex issues

In line with the discussion paper, participants stressed the need to treat AOD and mental health issues holistically, stating that AOD and mental health services tend to work well together, whether there is a formalised partnership or not. Participants shared some local level examples where AOD and mental health services worked well in collaboration, they felt this was due to pre-existing relationships rather than service design.

Overwhelmingly, stakeholders stated than AOD and mental health services in the Kimberley are not integrated, even if they are co-located and the two services use different approaches. The delivery of services to people with co-occurring issues is complex and requires several enablers such as: the right staff, service capacity, enabling service delivery models, cross-sector engagement and clear and accountable referral pathways. More emphasis needs to be placed on the integration of services as there is an increasing number of people who need access to simultaneous support.

People living in smaller towns and remote communities

Participants expressed their concern about the inadequacy of current community support and treatment services in meeting the needs of people living in smaller townships and remote communities. Some stakeholders stressed the cross-cultural nature of these communities and felt that services are not catered to address this nor were staff adequately supported to gain this understanding. This coupled with language barriers creates significant barriers to service provision.

Participants commented on the need for there to be a renewed focus on developing more frequent, intensive and flexible outreach services that could meet the needs of those remote populations who cannot readily access main treatment hubs.

Some stakeholders mentioned the need to partner with remote area clinics and other service providers to enable the outreach required to encompass the widespread Kimberley population.

Aboriginal people

The majority of stakeholders highlighted that more needs to be done to redesign the current AOD and mental health service system to be a culturally secure system which better meets the needs of Aboriginal people. Some participants said if this happens, more Aboriginal people would be inclined to access support.

Further, the point was made that if this was to occur there would be an urgent need to expand current services to meet spikes in demand. Aboriginal stakeholders stressed the need for family and community involvement in service design and delivery and that culture needs to be central to treatment and recovery.

Family

As alluded to in Section 4.1, a family-centred approach to AOD and mental health services is considered paramount by stakeholders to a successful AOD service system in the Kimberley. This extends to the need to prioritise family specific care and support for family members of service users. For example, stakeholders mentioned the need to better support children when an adult family member needs to access treatment services that require time away from the family. They wanted community-based options to support children impacted rather than the involvement of statutory authorities, like Department of Communities (Child Protection). People noted that in some cases, the fear of statutory involvement with their children was a reason people did not access AOD services.

Some stakeholders mentioned the need to support and educate children and young people on what to do if their parent or carer is using AOD. There was a strong overarching message on the importance of a family-centred AOD and mental health service system and the need to treat families holistically when a family member required services.

Older adults

Aging adults across the regions were a concern for stakeholders, reporting that some people in the Kimberley are often much younger than in other locations when they start requiring aged care support. People felt that if this was better understood by the AOD and health services sectors, the system can adjust to support and intervene earlier, through services such as intensive home visiting and personal support services. Stakeholders also felt that GP need to play a more proactive role in supporting older adults to access AOD information and treatment through referral and coordination of health plans.

Participants discussed the fact older adults who have long term AOD issues often have complex health issues and/or experience a health crisis that requires them to move into supported living options. Residential options are limited in the Kimberley and often at full capacity. In these situations, the only option available is for individuals to relocate to another part of WA, mostly typically metropolitan Perth. This dislocates them from their family, friends, community and country (for Aboriginal people).

Stakeholders also felt that aged care facilities were not well equipped to manage the AOD support needs of older adults and more could be done to build the capacity of this service system.

Non-aboriginal people

There were some diverse stakeholder opinions when discussing whether the AOD service system in the Kimberley catered adequately for non-Aboriginal people. Most expressed strongly that services were available to everyone and that AOD use was an issue for Aboriginal people and non-Aboriginal people across the region. Some acknowledged that there was a perception in the region that this was not always the case and that there was a general attitude that Aboriginal people are more likely to be impacted by AOD issues and that this drove poor stereotyping and service bias. Others commented that many non-Aboriginal people with AOD issues access community-bed based support and other treatment options outside of the region, stressing that this was a preferred option for many people state-wide and not unique to the Kimberley. GPs were considered to have a larger role in the treatment plans for Aboriginal people than non-Aboriginal people. A few stakeholders discussed the need to include tailored non-Aboriginal services within the service system, and consideration needed to be given to specific groups such as fly-in-fly-out (FIFO) workers with problematic AOD use living in the Kimberley.

4.10Prioritisation of services development within the Kimberley

As outlined in the discussion paper, there are opportunities to further enhance AOD services in the Kimberley region. The discussion paper presents a summary of an AOD service gap analysis, highlighting the following eight service areas as services that are not currently operating in the Kimberley and questioning the prioritisation of expanding into these areas.

- harm reduction and personal support
- safe places for intoxicated people (youth)
- post residential rehabilitation (youth)
- community day treatment programs (youth and adult)
- residential rehabilitation (youth)
- low-medical withdrawal (home-based, outpatient and other)
- high/complex withdrawal (inpatient)
- consultation and liaison services (mental health and AOD).

Participants in face-to-face consultations and through the online survey were asked to rank these services in order of prioritisation. Surprisingly, while stakeholders did rank these expanded services and believed some of them could be incorporated across the region to strengthen the service system, stakeholders unanimously agreed that the current services; prevention, community support, community treatment and community bed-based services need to remain the key focus. Stakeholders stressed that these services need to be better designed and delivered, with more resourcing, before additional services can be introduced in the region.

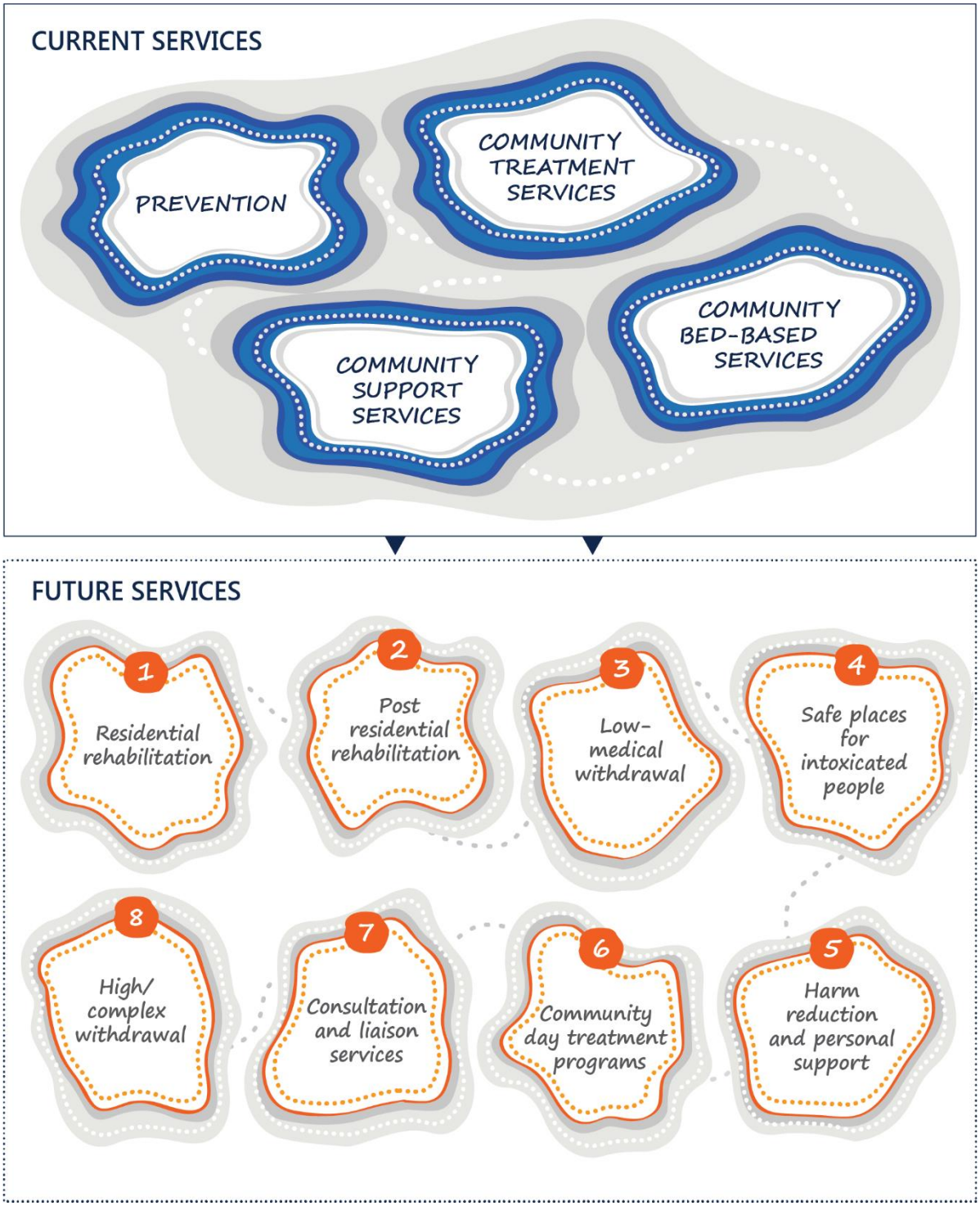
Stakeholders felt strongly that the ideas presented in the cross-cutting themes sections and the individual service topics are implemented, before the service system expands into new service areas.

"These additional services are great and may be effective, but we really have to focus on redesigning current services to deliver better outcomes"

- Service provider, Kimberley region

The figure below depicts the prioritisation of service expansion for AOD services in the Kimberley, reiterating the need to retain current services in the forefront and ensure these services are sufficiently resourced, before expanding into new services. Stakeholders noted that expansion of future services should be largely focussed on options for priority target groups, especially young people. The prioritisation of future services is displayed overleaf in Figure 5, with residential rehabilitation for youths gaining the most attention while high/complex inpatient withdrawal is the lowest priority for Kimberley stakeholders.

Figure 5 | A representation of service prioritisation feedback. Current services remain a priority while future services were ranked in order of importance by participants.



5 Appendices

5.1 Attendance

Table 1 | Targeted face-to-face consultations

Organisations and network groups	
Milliya Rumurra Aboriginal Corporation	WA Network of Alcohol and Other Drug Agencies
Cyrenian House	Western Australian Association of Mental Health
WA Country Health Services	WA Primary Health Alliance
Garl Garl Walbu	Aboriginal Health Council of WA
Nindilingarri Cultural Health Services	Broome Alcohol and Other Drug Management Group
Waringarri Aboriginal Corporation	Derby Alcohol and Other Drug Management Group
Warmun Community (Turkey Creek) Inc	Kimberley Aboriginal Health Planning Forum
Alive and Kicking Goals	Kimberley District Leadership Group
Mens Outreach	Fitzroy Valley Futures
Local Drug Action Group	

Table 2 | Service provider workshops

Organisations	
MG Corporation	Juvenile Justice
Wunan	Milliya Rumurra Aboriginal Corporation
Child Protection (EK)	WAPHA
Child Protection (WK)	Department of the Prime Minister and Cabinet
Headspace	Boab Health
Ngnowar-Aerwah Aboriginal Corporation	Kimberley Mental Health and Drug Services (WACHS)
Dept of Education (Kimberley)	Broome Youth and Families Hub
Kununurra District High School	Save the Children
Broome District High School	

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