fiftyfive5

circa Cultural & Indigenous Research Centre Australia

Department of Health

Consultation to Inform Funding for Alcohol and Other Drug Treatment Services to Support CDC Trial Participants

Final Report

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Executive Summary

PART ONE: Overview of consultation, community AOD needs, current provision of AOD treatment service and gaps

BACKGROUND

In 2016, the Australian Government began a staged implementation to the roll out of the Cashless Debit Card (CDC) to ensure that welfare payments are spent in responsible and meaningful ways by restricting the use of income support payments to purchase alcohol, illicit drugs or gambling products.

In the 2021-22 Budget, the Federal Government announced funding of $49.9 million over four years to establish and support alcohol and other drug treatment services for the CDC sites of Ceduna, East Kimberley, the Goldfields and Bundaberg & Hervey Bay Regions.

RESEARCH APPROACH

Fiftyfive5 and CIRCA were commissioned to conduct consultation to inform decisions on expenditure to establish new and support existing alcohol and other drug treatment services for each of the four CDC sites.

PHASE 1
AILIGNMENT:
- REA
- Interviews with expert stakeholders

PHASE 2
CONSULTATIONS:
- 47 x Local community stakeholders
- 25 x Commonwealth, state and non-governmental agency representatives

COMMUNITY AOD NEEDS

Stakeholders described a complex interplay of the social and health issues that are central to problematic AOD use. There were many consistencies in the social and health issues across the four CDC locations, notably homelessness, unemployment, intergenerational trauma, racism/discrimination, poverty and comorbid mental health problems. Homelessness and lack of affordable housing was a particular issue identified, with this seen to perpetuate AOD problems.

The specific AOD needs also varied between locations, with drug use considered more problematic in some areas, and health and social issues presenting notable concerns in others.

KEY GAPS IN CURRENT SERVICE PROVISION

All regions identified strong benefits from increased investment in AOD treatment services. However, there were also region-specific needs identified.

BUNDABERG AND HERVEY BAY
- **GAPS:** Rehabilitation center (one opening 2022/23); counselling clinical care co-ordination services, post-treatment services

CEDUNA
- **GAPS:** Rehabilitation centre; detoxification services and post-treatment services

EAST KIMBERLEY
- **GAPS:** Culturally appropriate out of hours services; broader AOD and health workforce gaps

GOLDFIELDS
- **GAPS:** Prevention services, cohort-specific services (i.e., youth and women), outreach services

PART TWO: AOD service gaps, guidance for development of a grant programme and recommendations

GAPS:
Although each CDC location has distinct AOD current service provision and needs, the gaps in service delivery predominantly relate to four main areas

General AOD treatment services

All areas had limited access to in-patient rehabilitation, as well as need for outreach in all areas.

Targeted AOD treatment services

Lack of services supporting the needs of specific groups, particularly Aboriginal and Torres Strait Islander peoples, youth and women.

Workforce

All areas identified workforce gaps, notably lack of Aboriginal staff and difficulty attracting qualified staff. Local issues are outlined in the report.

Infrastructure and social support

Services cannot tackle AOD issues without also addressing basic needs. Demand for access to employment and housing services was high in all areas.

HOW TO FILL THE GAPS....

- **Scaling-up current provisions of services**
- **Greater levels of interagency collaboration and communications**
- **Training and capacity building**
- **Local engagement and community-led decision making**

SUCCESS WITH GRANT FUNDING

- Localised approach that is informed by local knowledge such as EC or ACCHOs
- Driven by community need
- Delivered or partnered with local service providers
- Builds capacity of local service providers
- Community engagement and decision making
- Appropriate length of funding

DOWNFALLS

- Restricted grant funding application process
- Strict grant monitoring and reporting (i.e., enhanced use of outcome focused KPIs)
- Short-term nature of funding
- Duplication
- Vast regions for service delivery

Given the unique characteristics and needs of each CDC region, grant funding will need to be localised and targeted in each area. However, stakeholder suggestions related to the parameters and requirements of a grant program are consistent and can be applied across all four locations.

Our nine recommendations focus on the treatment needs across the CDC trial sites, maximising the provision for vulnerable groups, workforce training and capacity building, enhancing localisation and collaboration in service provision, and the more tactical elements of the grant process.

RECOMMENDATIONS:

PROVISION OF SPECIALIST TREATMENT

01 Consideration of area-specific needs should inform grant funding of specialist treatment in each location

ENSURING KEY GROUPS ARE PROVIDED FOR

02 Prioritise grant applications that consider specific sub-groups needs and fund tailored services (i.e., youth, gender-specific, family, culturally safe, and community-controlled services), as well as grants that ensure appropriate staffing

TRAINING AND CAPACITY-BUILDING

03 Given the need for appropriate staffing, precedence should be given to grant applications with plans to attract and retain qualified staff or build the capacity of local people, notably those who identify as Aboriginal and Torres Strait Islander peoples

04 Long-term grant funding may increase attraction of grants to service providers, facilitate recruitment of appropriate staff, as well as enhance impact of service delivery on the local community

ENHANCING THE ABILITY OF LOCAL SERVICES TO BE DELIVERED IN COMMUNITY

05 Due to the desire for AOD services to be delivered at the point of need, grant applications that provide an outreach service, or offer to extend a current outreach service should be prioritised

COLLABORATION BETWEEN SERVICE PROVIDERS

06 Grants that initiate or enhance systems to enable collaboration between service providers should be prioritised

ENGAGING WITH, AND UNDERSTANDING, LOCAL DELIVERY PARTNERS

07 Grants should consider how they meet criteria (informed by evidence; consideration of local need; culturally safe and person-centred). Inclusion of NIAA, Empowered Communities and state-based AOD representatives in review of grant applications would be beneficial

08 Consider building KPIs or other accountability metrics into grants awarded to allow community stakeholders to appraise the performance of a provider

ADMINISTERING A GRANT PROCESS FOR MAXIMUM POSITIVE OUTCOMES

09 Grant applications from local community organisations that led or act as a partner for the service delivery should be prioritised. In particular, any grants that incorporate capacity building of local services

List of Abbreviations

Component	Description
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ACCO	Aboriginal Community Controlled Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
Card	The Cashless Debit Card
CDC	Cashless Debit Card
CIRCA	Cultural & Indigenous Research Centre Australia
KPIs	Key Performance Indicators
ISP	Income support payments
N	Number of observations
REA	Rapid evidence assessment

Acknowledgement

Fiftyfive5 and CIRCA would like to thank all of those who participated in the consultation and reviewed early drafts of the report. The generous provision of the time and insights from these stakeholders helped to strengthen the report findings and recommendations.

1. Introduction

This report presents the findings of consultation undertaken to inform the grant funding decision-making process for the delivery of alcohol and other drug treatment services for four Cashless Debit Card (CDC) trial sites.

Background

The Cashless Debit Card trial

In 2016, the Australian Government began a staged implementation to the roll out of the CDC for income support payments (ISPs) in multiple locations across Australia. The CDC aims to ensure that welfare payments are spent in responsible and meaningful ways by restricting the use of ISPs to purchase alcohol or gambling products. The CDC was introduced in specific locations that exhibit high levels of welfare dependence in conjunction with high levels of social harm associated with alcohol consumption, illicit drug use and gambling.

Currently, there are six locations that have introduced the CDC, but the current consultation report focuses on four of the locations (all aside from Northern Territory and Cape York and Doomadgee, QLD). There is some variation in the eligibility criteria between locations. In Ceduna, Goldfields and East Kimberley regions the CDC is compulsory for anyone with a working age welfare payment. In contrast, the CDC is only compulsory for individuals aged 35 years and under who receive JobSeeker Payment, Parenting Payment or Youth Allowance in the Bundaberg and Hervey Bay region. In all regions, Individuals who are not required to use the CDC may also volunteer to be part of the program.

In all four CDC regions, participants on the CDC receive:

- 20 per cent of their welfare payment in their regular bank account.
- 80 per cent of their welfare payment onto the CDC.

Since the implementation of the trial, there have been three evaluations conducted to assess its effectiveness. Initially, the CDC Trial Evaluation was run by ORIMA Research in 2017 and assessed the trial against a list of Key Performance Indicators (KPIs). In 2021, the University of Adelaide conducted an evaluation of the trial in three regions - Ceduna, East Kimberley and the Goldfields. A separate evaluation was conducted for the Bundaberg and Hervey Bay Region by the University of Adelaide in 2020. Although these previous evaluations have assessed the CDC trial, these have predominantly been focused on the Card itself and only superficially reported on the broader context of alcohol and other drug treatment services delivery[1]. Furthermore, findings from these evaluations indicated that uptake and usage of the AOD services funded through the CDC trial was limited. Despite many CDC participants who reported that they intended to use services, the evaluation found minimal usage.

Additional AOD services

In the 2021-22 Budget, the Federal Government announced funding of $49.9 million over four years to establish additional and support existing alcohol and other drug treatment services for the CDC sites of Bundaberg-Hervey Bay, Ceduna, East Kimberley and the Goldfields Regions. Fiftyfive5 and CIRCA were commissioned to conduct a consultation to inform decisions on this expenditure.

[1] Please see Appendix C for more detail on the University of Adelaide and ORIMA Research Evaluation studies.

Objectives

The objectives guiding this consultation are as follows:

To undertake consultation to inform expenditure to establish new and support existing alcohol and other drug treatment services for each of the four existing CDC trial sites. Fiftyfive5 & Cultural & Indigenous Research Centre Australia (CIRCA) have designed and executed a consultation process that will:

- Ensure the new funding builds on and complements existing alcohol and other drug treatment services and maximises efficiency and effectiveness of service delivery
- Provide advice on the alcohol and other drug treatment needs of the four communities;
- Identify gaps in treatment services and the most effective and efficient method to fill those gaps; and
- Inform a grant process to deliver funding for new and existing treatment services in each location as required.

Approach

The approach to meeting these consultation objectives was divided into three phases; 1) alignment and immerse, 2) fieldwork, and 3) review and report. The alignment and immerse phase included workshops with the Department of Health, a Rapid Evidence Review and interviews with expert stakeholders.

The second phase was a series of interviews considering the needs and provision of services from two perspectives: 1) State and Commonwealth Governments; and 2) Community. The Fiftyfive5 consultation team interviewed twenty-five individuals from Commonwealth funding bodies, State Health Departments or State-based agencies funding alcohol and other drug services, Primary Health Networks and Alcohol and Other Drug Peak Network Representatives providing an overview of the experiences and needs of those designing and delivering services.

The second perspective was managed by CIRCA and captured the experiences of service providers based in each region. The interviews included representatives from local Aboriginal Community Controlled Health Organisations (ACCHOs), local mainstream health service providers, local Alcohol and Other Drug (AOD) service providers and local Aboriginal community leaders knowledgeable about local AOD treatment needs, services, and context.

Across the two teams leading the consultation interviews there were people from Aboriginal and Torres Strait Islander backgrounds, however this was in the CIRCA team and not the Fiftyfive5 team. All interviews in the four communities were conducted by CIRCA's local Aboriginal Research Consultants.

Table 1: Number of people interviewed by CIRCA, from each cohort

Stakeholder type	Ceduna	East Kimberley	Goldfields	Bundaberg / Hervey Bay
Aboriginal Community Controlled Health Organisations (ACHHO)	**2**	**2**	**2**	**2**
Local mainstream health service providers	**3**	**2**	**2**	**2**
Local alcohol and other drug service providers	**3**	**3**	**3**	**5**
Aboriginal Community leaders	**5**	**5**	**5**	**2**[2]
Total	**13**	**12**	**12**	**11**

This report is based primarily on the issues highlighted in these interviews, where points are supported by secondary literature, this is referenced. Throughout all sections of this report where community perspectives are outlined and explored, the input, perspectives, and viewpoints of all these community representatives (including ACCHOs) have been reflected, even if direct quotes from them are not cited.

[2] In the Bundaberg-Hervey Bay area we interviewed fewer than the intended five Aboriginal community leaders because we found that Aboriginal Community Leaders there were either unavailable or not willing to participate, due to limited confidence discussing the topic or wariness to openly speak about AOD.

2. Findings from previous studies and the implications for this report

In this section, we provide an overview of the characteristics and demographics of the four trial sites to provide context for the discussion of local alcohol and other drug services and community needs. This section utilises publicly available data to provide an overview of the people with AOD dependence from each CDC region, findings from the rapid evidence assessment (REA) provide an overview of evidence related to CDC trial participants and the implications for this consultation report.

Findings from previous research and consultation

In the initial stages of the consultation, Fiftyfive5 conducted a REA to form a knowledge base of existing resources and information related to the CDC trial, as well as identify any implications for the current consultation report. As a result, the findings from the REA shaped our approach to data collection with stakeholders, service providers and Indigenous community leaders and ensured that views from relevant cohorts were included.

The review of previous studies also provided oversight of the background of the CDC and consideration for the current consultation report. Of note, the CDC Trial Evaluation (2017) and Evaluation of the CDC in Ceduna, East Kimberley and the Goldfields (2021) reported that there was low awareness and uptake of additional support services funded as part of the CDC trial. These evaluations indicated that funding for additional services was allocated according to restricted criteria and resources which favoured traditional AOD services (e.g. rehabilitation and drug and alcohol counselling) rather than holistic care and broader wraparound services to address participants' needs (e.g., case management services).

The location of additional support services was identified as a barrier for many CDC participants, particularly those located in remote communities (ORIMA, 2017). There were minimal local support[3] services in remote areas and outreach services were reported to visit infrequently. The poor accessibility of services in remote areas impacted timeliness of support and quality of care.

The need for culturally sensitive support services was also identified due to the high proportion of Indigenous CDC participants (University of Adelaide, 2021). The inclusion of local Indigenous staff and organisations is considered to be fundamental to appropriately address the disproportionate harms experienced by Indigenous CDC participants, as well as ensuring that additional support services operate in a culturally sensitive manner. These findings were aligned with the Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector (2014) report that identified a gap in accessibility of culturally safe AOD services, with the recommendation that Aboriginal and Torres Strait Islander control of services was required to ensure AOD treatment is culturally safe and appropriate.

While there was consensus that additional support services were necessary to reduce social harm and enhance the effectiveness of the CDC, the resources indicated that the funding of support services had been insufficient to make a sustainable impact on the local communities (ORIMA, 2017; University of Adelaide, 2021). The CDC Trial Evaluation (2017) identified that the short-term funding arrangements were problematic (including impact on staffing) and prevented support services from establishing long-term change among individuals and communities. Furthermore,

[3] In reviewer comments there was a desire for clarity in the use of support and treatment. Fiftyfive5 has sought to deliver this where possible, however in reference to other research and consultation we are limited by the use of language in these published reports.

there was reportedly a lack of co-ordination between community-based AOD, health and other social services which disrupted the participant treatment journey. According to the Patient Pathways study (Turning Point, 2014), there is a need for future funding models to improve co-ordination and referral pathways between services, as well as accommodate and promote treatment journeys that involve multiple treatment modalities.

Overview of the trial sites

In this section, we have used Census (2016) data to provide an overview of the demographic context from all four CDC regions included in this report. This section is intended to provide context for the later discussion of community AOD needs. It is important to note that although the statistics presented provide a useful introduction, they should be considered alongside the information from practitioners, to ensure omissions from the data are fully understood.

Due to the varying size and geographical areas of each CDC region the data is not comparable between regions. Instead, the contextual picture from each region should be used to provide background understanding to the context in which AOD treatment services are delivered in each area.

Ceduna region

Figure 1 Demographic overview of Ceduna region

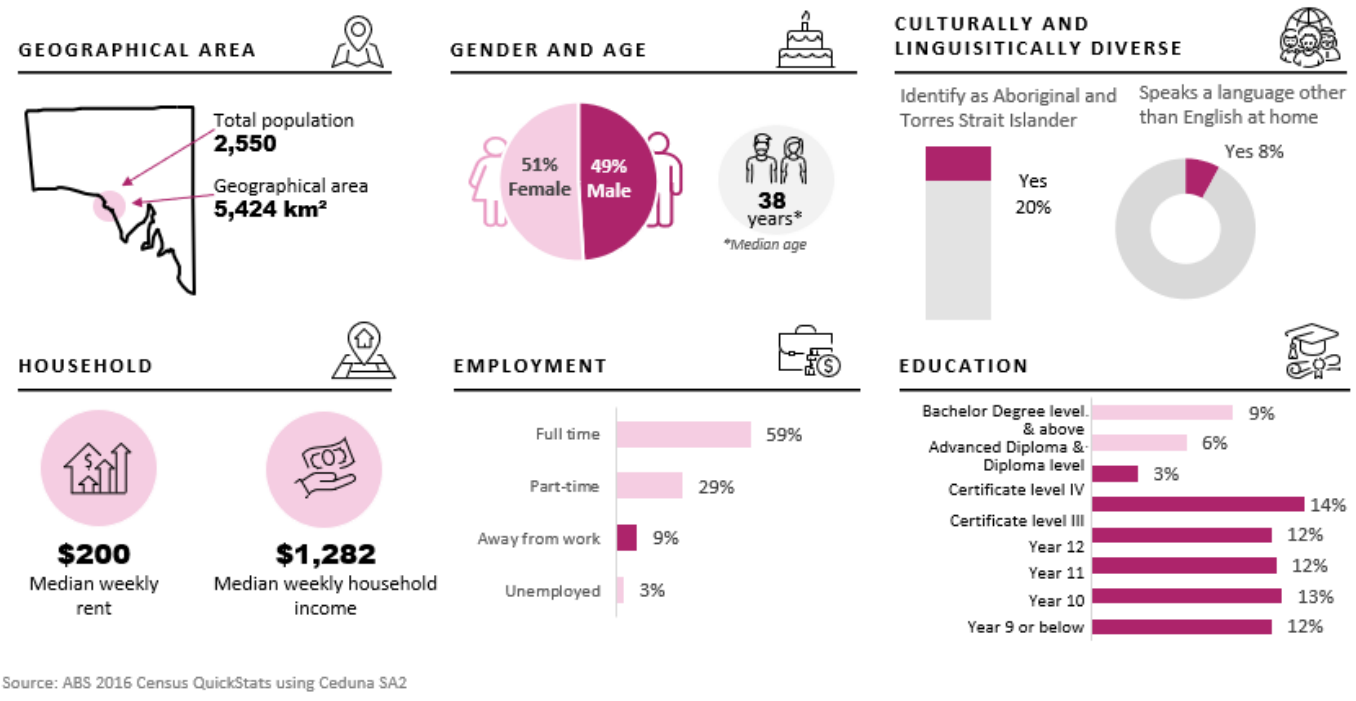


Figure 1 above provides a visual representation of the demographic data of the Ceduna region. For a full explanation of Figure 1 see Table 2 in Appendix A.

Source: ABS (2016). QuickStats using Ceduna LGA to define location.

The Ceduna district in South Australia was the first region to trial the CDC, which began on 15 March 2016. The CDC trial operates in the township of Ceduna and surrounding communities of Koonibba, Scotdesco, Yalata and Oak Valley. Located on the Far West Coast of South Australia, the Ceduna district is in a relatively remote area and approximately 800 kilometres from Adelaide. Among the CDC regions, Ceduna is the second smallest in terms of geographical area and smallest by number of inhabitants (around 3,400 people).

There are several Aboriginal and Torres Strait Islander communities situated near Ceduna, including the Koonibba community, Scotdesco community, Yalata Anangu Aboriginal community and the Maralinga Tjarutja (Oak Valley) communities included in the trial. According to the 2016 Census (ABS 2016a), more than one fifth (22%) of residents identified as Aboriginal and Torres Strait Islander peoples.

In Ceduna, the IRSD score is 965 (which is in the 2nd quintile of most disadvantaged areas in Australia) indicating that this region has high levels of disadvantage. The median weekly rent ($186) in Ceduna was the lowest when compared to the other CDC regions, with this area having a higher proportion (10%) of public housing compared to the Australian median (4%). While the cost of housing is lower, the median household income was also low ($1,254 per week). Despite a relatively low unemployment rate (3%), there is a high proportion in part-time work (29%).

Ceduna Health services

Given the smaller geographical area and remoteness of Ceduna, there is less access to health services in this region. The Ceduna district and surrounding communities is part of the County SA PHN. The Ceduna District Health Services includes one hospital, 'GP Plus' service and the Ceduna/Koonibba Aboriginal and Torres Strait Islander Health Service. There are also five Aboriginal Community Controlled Health Organisations (ACCHOs) in this area led by South Australian West Coast ACCHO Network (SAWCAN).

There is no residential rehabilitation centre near Ceduna, with the closest located in Port Augusta (470km away). There is some access to AOD specific health services, with two Sobering up services based in Ceduna along with other outpatient AOD services.

AOD issues in Ceduna region

This section provides data on the people with AOD dependence using statistics from the AIHW National Drug Strategy Household Survey (2020) at a Statistical Area Level 4 (SA4). While we acknowledge that this is not a completely accurate representation of the people with AOD dependence population in the CDC regions, these statistics allow comparison between the four regions and provide information related to the context of these areas.

In 2019, the lifetime prevalence of risky alcohol consumption was estimated to be 26.9% in the South Australia Outback statistical area (including the Ceduna region), which is higher than the national average (16.8%) and average for inner regional areas (18.2%). In this Statistical Area, the rate of recent illicit drug use was lower (15.2%) than the national average (16.4%) but higher than the average for inner regional areas across Australia (14.9%).

These statistics demonstrate high levels of risky alcohol behaviour in the Ceduna region. While the recent illicit drug use was higher than the average for inner regional areas across Australia, these statistics suggest that alcohol dependence may be a more important priority area compared to other illicit substances.

East Kimberley region

Figure 2 Demographic overview of East Kimberley region

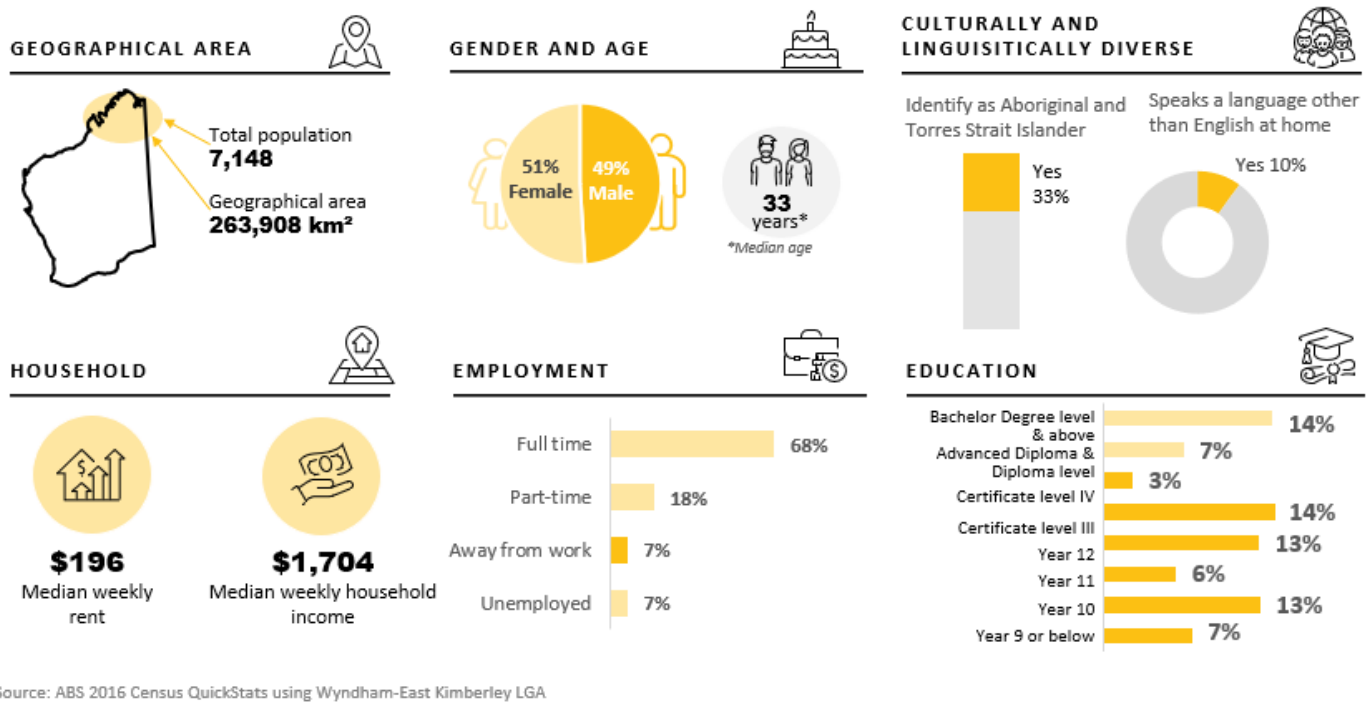


Figure 2 above provides a visual representation of the demographic data of the East Kimberley region. For a full explanation of Figure 2 see Table 4 in Appendix A.

Source: ABS (2016). QuickStats using Wyndham-East Kimberley LGA to define location.

The East Kimberley region commenced the CDC trial on 26 April 2016. The East Kimberley region is remote and covers the second largest geographical area of the CDC regions included in the consultation (263,908 km km²). This CDC region is dispersed, with vast distances between the two main townships of Kununurra and Wyndham and surrounding communities, as well as significant distances to any large urban areas.

The East Kimberley region has a relatively small population (7,148), with the majority living in Kununurra (5,308) and Wyndham (780). A substantial proportion of the overall population identifies as Aboriginal and Torres Strait Islander (33%), with this the highest among the CDC regions included in the consultation. Of the CDC regions, the East Kimberly has the second highest rates of households that do not speak English at home (10%).

Alongside the Goldfields region, the East Kimberley region has an Index of Relative Socio-economic Disadvantage (IRSD)[4] score (917) which is in the quintile with the highest level of socio-economic disadvantage. The East Kimberley region has the second highest weekly median household income ($1,704) of the CDC regions, as well as the second

[4] *Socio-Economic Indexes for Areas (SEIFA) is an ABS product that ranks areas in Australia according to relative socio-economic advantage and disadvantage. This uses four indexes that are based on information from the Census. We have reported on one of the indexes - the Index of Relative Socio-economic Disadvantage (IRSD) - which is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. Unlike the other indexes, this index includes only measures of relative disadvantage. A low score indicates relatively greater disadvantage in general. For example, an area could have a low score if there are many households with low income; many people with no qualifications, or; many people in low skill occupations.*

lowest median weekly rent ($196). The rate of unemployment in East Kimberley is equivalent to the national average (7%).

East Kimberley Health services

The East Kimberley region is remote, with most health services concentrated in Kununurra and, to some extent, Wyndham. While these areas have a hospital, Primary health, community health and Aboriginal and Torres Strait Islander Health services in each location[5], other surrounding communities have limited access to health services. Furthermore, there are no acute mental health inpatient units in the East Kimberley region of Western Australia. The closest inpatient mental health unit is located in the Broome Hospital (1,043 kilometres, or an 11-hour drive from Kununurra), which has a total of 13 beds.

The accessibility of AOD-specific health services is also location dependent, with a residential rehabilitation centre located in Wyndham. Alternatively, residents would need to travel to Broome. There are two sobering up services in East Kimberley, including an overnight facility for people who are highly intoxicated, however there are minimal specialist AOD treatment services for people to be referred to. Residents also have access to *a region-wide Community Alcohol and other Drugs Service.*

AOD issues in East Kimberley region

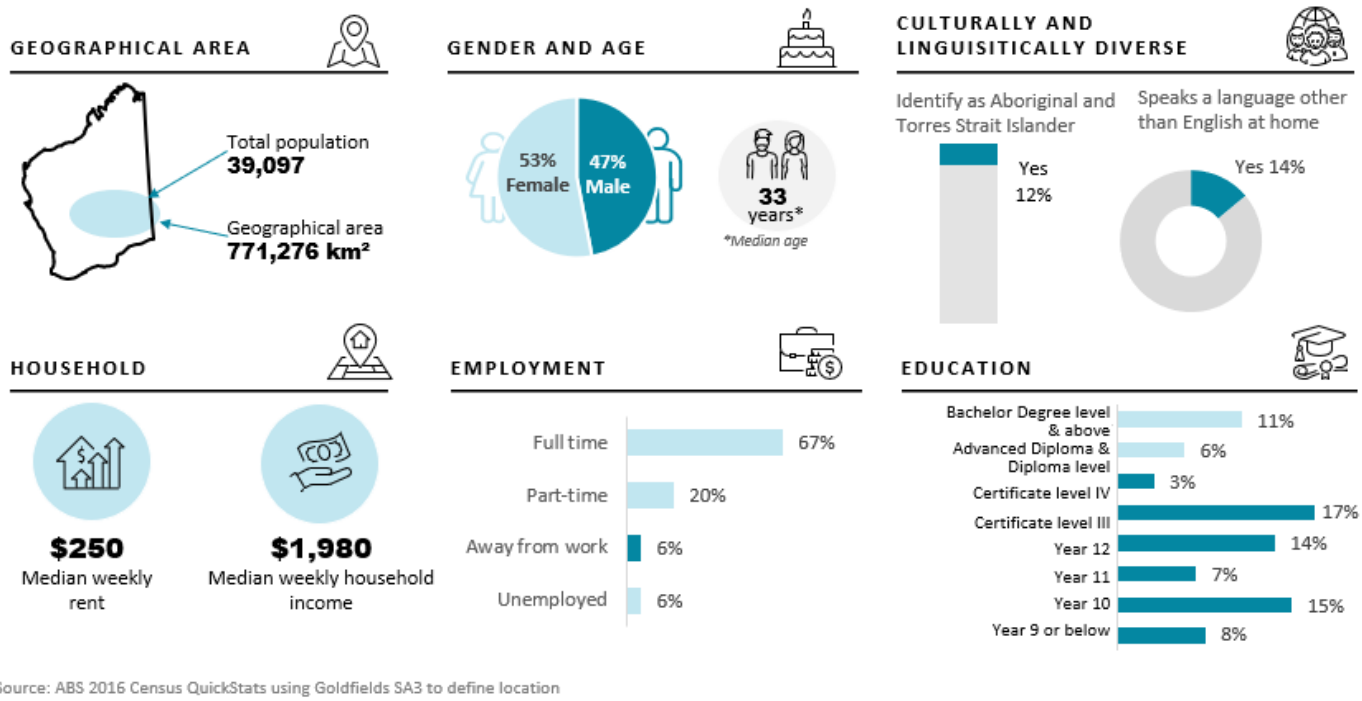
The lifetime prevalence of risky alcohol consumption was the highest in the Western Australia Northern Outback (Statistical Area Level 4 including the East Kimberley region) compared to other CDC regions. This was estimated to impact one third of the population (33%) which is higher than the average for remote/very remote areas across Australia (25.5%). The rate of recent illicit drug use was also the highest in this area (22.8%) compared to the national average (16.4%) and remote/very remote areas (18.8%).

These statistics demonstrate high risky alcohol behaviour and recent illicit drug use in the East Kimberley and surrounding region. These statistics suggest that illicit drug use may be a more important priority area compared to other CDC regions, notably Bundaberg-Hervey Bay and Ceduna.

[5] For example, Ord Valley Aboriginal Health Services Aboriginal Corporation (OVAHS) is an ACCHO, which from its base in Kununurra it operates a mobile clinic that visits 25 remote communities.

Goldfields region

Figure 3 Demographic overview of Goldfields region



Source: ABS 2016 Census QuickStats using Goldfields SA3 to define location

Figure 3 above provides a visual representation of the demographic data of the Goldfields region. For a full explanation of Figure 3 see Table 5 in Appendix A.

Source: ABS (2016). QuickStats using Goldfields SA3 to define location.

The Goldfields region was the second Western Australian region to commence the CDC trial on 26 March 2018. The Goldfields region is the largest CDC region (771,276 km²) and covers the South Eastern corner of Western Australia. This CDC region also has the second largest population (39,097).

The Goldfields region is made up of several local government areas (Kalgoorlie-Boulder, Laverton, Leonora, Coolgardie and the Shire of Menzies) with diverse populations, socio-economic conditions and levels of urbanisation. Furthermore, these local government areas vary in their accessibility and remoteness. For example, the City of Kalgoorlie-Boulder is the largest outback city in Western Australia due to the mining industry and large fly-in/fly-out (FIFO) workforce. In contrast, the shire of Menzies is far more remote with a small population (490) with a high proportion of people that identify as Aboriginal and Torres Strait Islander (45%[6]).

Areas within the Goldfields region have IRSD scores in the quintile with the highest disadvantage (for example LGA of Laverton has a score of 709). Of the CDC regions included in the consultation, the Goldfields region had the highest median weekly household income ($1,980) and the second highest median weekly rent ($250).

Goldfields Health services

Given the large geographical area, there is wide variation in the accessibility of health services throughout the region and individuals located in more remote communities need to travel long distances to access health services. There are hospitals located in Kalgoorlie, Laverton and Leonora, and Primary health, community health services and

[6] ABS 2016 Quick Stats using Mezies LGA to define the location

Aboriginal and Torres Strait Islander Health services are more common in these locations[7]. The Kalgoorlie Acute Psychiatric Unit has six beds for adults, with additional community based mental health services for children, adolescents, adults and older adults.

There is a residential rehabilitation centre in Kalgoorlie for residents of the Goldfields area, with one sobering up service also located in Kalgoorlie. Given the wide geographical area, this would require traveling long distances for people located in more remote areas of the Goldfields region. However, there is also a *region-wide Community Alcohol and other Drugs Service.*

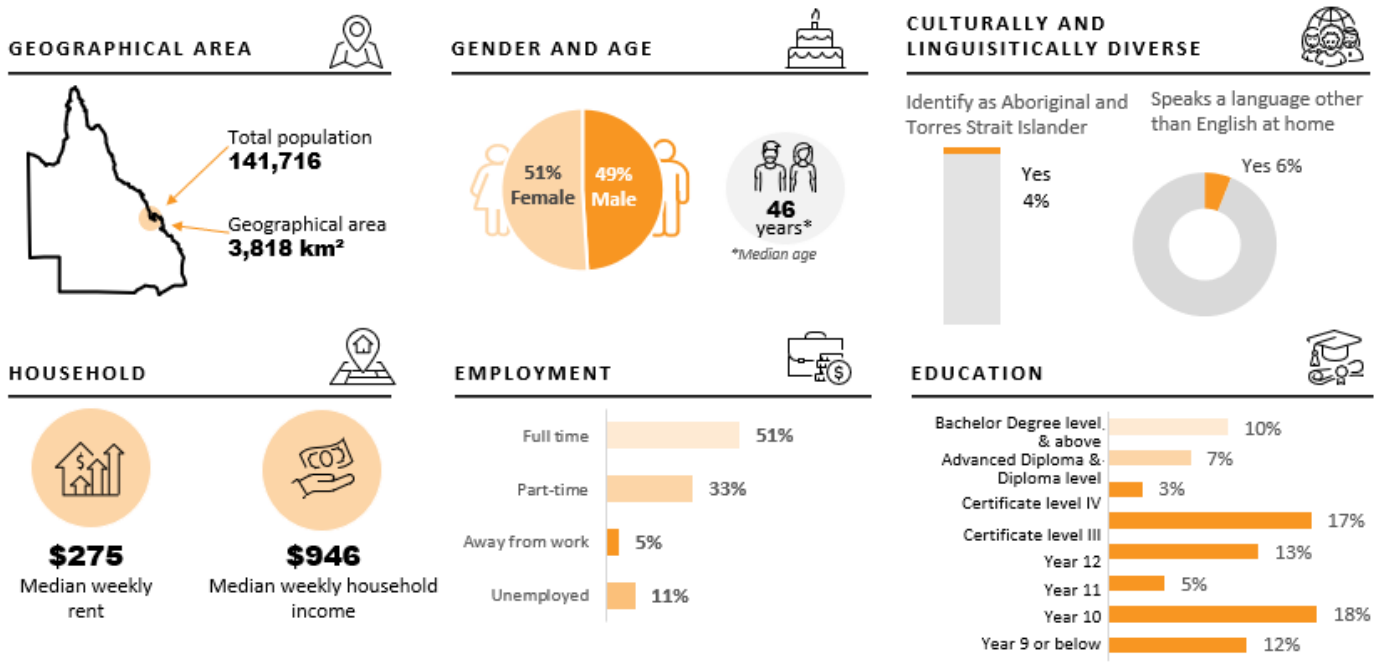
AOD issues in Goldfields region

In 2016, the lifetime prevalence of risky alcohol consumption was estimated to be 31.7% in the Western Australia Outback (Statistical Area Level 4 including the Goldfields region)[8] which was higher than the average for remote/very remote areas (26.2%) and national average (17.2%). The rate of recent illicit drug use was also the highest in this area (25.9%) compared to the national average (15.6%) and remote/very remote areas (24.8%) in 2016).

Although data was not available in 2019 for this statistical area, there is evidence to suggest high levels of risky alcohol behaviour and recent illicit drug in the Goldfields area. This suggests that both alcohol dependence and illicit drug use may be a priority area for this region.

Bundaberg and Hervey Bay region

Figure 4 Demographic overview of Bundaberg and Hervey Bay region



Source: ABS 2016 Census QuickStats using Federal electorate of Hinkler to define location

7 For example Bega Garnibirringu Health Services Incorporated (BGHS) is an ACCHO that has a clinic in Kalgoorlie with a mobile clinic visiting the remote communities of Coolgardi, Esperance, Leonora, Menzies, Mount Margaret and Norseman, and Paupiyala Tjarutja Aboriginal Corporation's Spinifex Health Service (SHS) is an ACCHO established for the Tjuntjuntjara Community on the Spinifex Lands.
8 *data not available for 2019 for Western Australia Outback SA4

Figure 4 above provides a visual representation of the demographic data of the Bundaberg and Hervey Bay region. For a full explanation of Figure 4 see Table 6 in Appendix A. Source: ABS (2016). QuickStats using Federal electorate of Hinkler to define location.

The CDC trial was introduced most recently in the Bundaberg and Hervey Bay region on the 29th of January 2019. In the other three CDC regions included in the consultation, all individuals receiving a working age payment are eligible for CDC. In contrast, the CDC is compulsory for individuals aged 35 years and under who receive a JobSeeker Payment, Parenting Payment or Youth Allowance in the Bundaberg and Hervey Bay region. Individuals who are older than 35 years or receiving the Age Pension can volunteer to use the CDC.

The Bundaberg and Hervey Bay region is defined by the boundaries of the Federal Electoral Division of Hinkler, which runs along the Queensland coast from Hervey Bay to Bundaberg. This also includes the townships of Aldershot, Bargara, Elliott Heads, Woodgate, Booyal, Burrum Heads, Torbanlea, Toogoom, Howard, Childers, Burnett Heads and River Heads. This is the CDC region with the smallest geographical area (3,818 km²).

Of all the CDC regions, this region has the largest population with 141,716 in the Hinkler electorate (ABS Census, 2016). It also has an older population compared to other regions (median age is 46 compared to 38 in Ceduna and 33 in East Kimberley and Goldfields), with 37% of the population aged younger than 35 years. This region has the lowest Aboriginal and Torres Strait Islander population (4%) of the CDC regions included in the consultations. This region also has less cultural diversity compared to other regions; with 6% of households where a non-English language is spoken.

Similar to the other CDC regions, the Bundaberg and Hervey Bay region has high levels of disadvantage (using the IRSD score). In Bundaberg, the IRSD score is 925[9] which is in the 2nd quintile for disadvantage. When considering the distribution of the population of the Federal electorate of Hinkler in relation to these IRSD, almost half of the population is in the lowest decile of the IRSD distribution (the lowest 10% of areas in Australia).

Among the CDC regions, the Bundaberg and Hervey Bay region has the highest unemployment rate (11%) with around half the population engaged in full-time employment (55%). This region also has the lowest weekly median household incomes ($947) and highest weekly rent ($275) of all the CDC regions included in this consultation.

Geographically, this CDC region is distinct from other CDC regions included in the consultations, with a higher density population, closer proximity to a city and is also differentiated by demographics of population (i.e., aging population and lower Aboriginal and Torres Strait Islander population).

Bundaberg and Hervey Bay Health services

Given the high population density, comparative urbanisation and smaller geographical area, this region has greater access to a range of health services compared to other CDC regions. Both Bundaberg and Hervey Bay have hospitals, primary health, community health and Aboriginal and Torres Strait Islander Health services[10]. The Wide Bay Hospital and Health Service funds 18 full-time-equivalent AOD staff that work across disciplines throughout the region. This includes services in Bundaberg, Hervey Bay and one staff member in Gayndah. There are current plans by the Qld state government to build a residential rehabilitation for those in the Bundaberg-Hervey Bay region.

AOD issues in Bundaberg and Hervey Bay region

In 2019, the lifetime prevalence of risky alcohol consumption was estimated to be 23.6% in the Wide Bay statistical area, which is higher than the national average (16.8%) and average for inner regional areas across Australia (18.2%).

9 Total IRSD score not found for the federal electorate of Hinkler.

10 Galangoor Duwulami Aboriginal and Torres Strait Islander Corporation (Primary healthcare Service) is an ACCHO providing primary healthcare to Galangoor and surrounding areas across a number of sites located in Maryborough and Pialba.

This had also increased in Wide Bay since 2016 (18.8%). In the Wide Bay area, the rate of recent illicit drug use was lower (12.9%) than the national average (16.4%) and average for inner regional areas across Australia (14.9%). This had reduced from 2016 (18%).

These statistics provide context for the prevalence of drug and alcohol consumption in the Bundaberg and Hervey Bay region (as well as surrounding areas). While risky alcohol consumption was higher than the national average, recent illicit drug use was reported to be lower (AIHW, 2020). This suggests that risky alcohol consumption may be a more important priority area compared to other illicit substances.

CDC Trial participant population

Figure 5 Demographics of CDC participant populations[11]

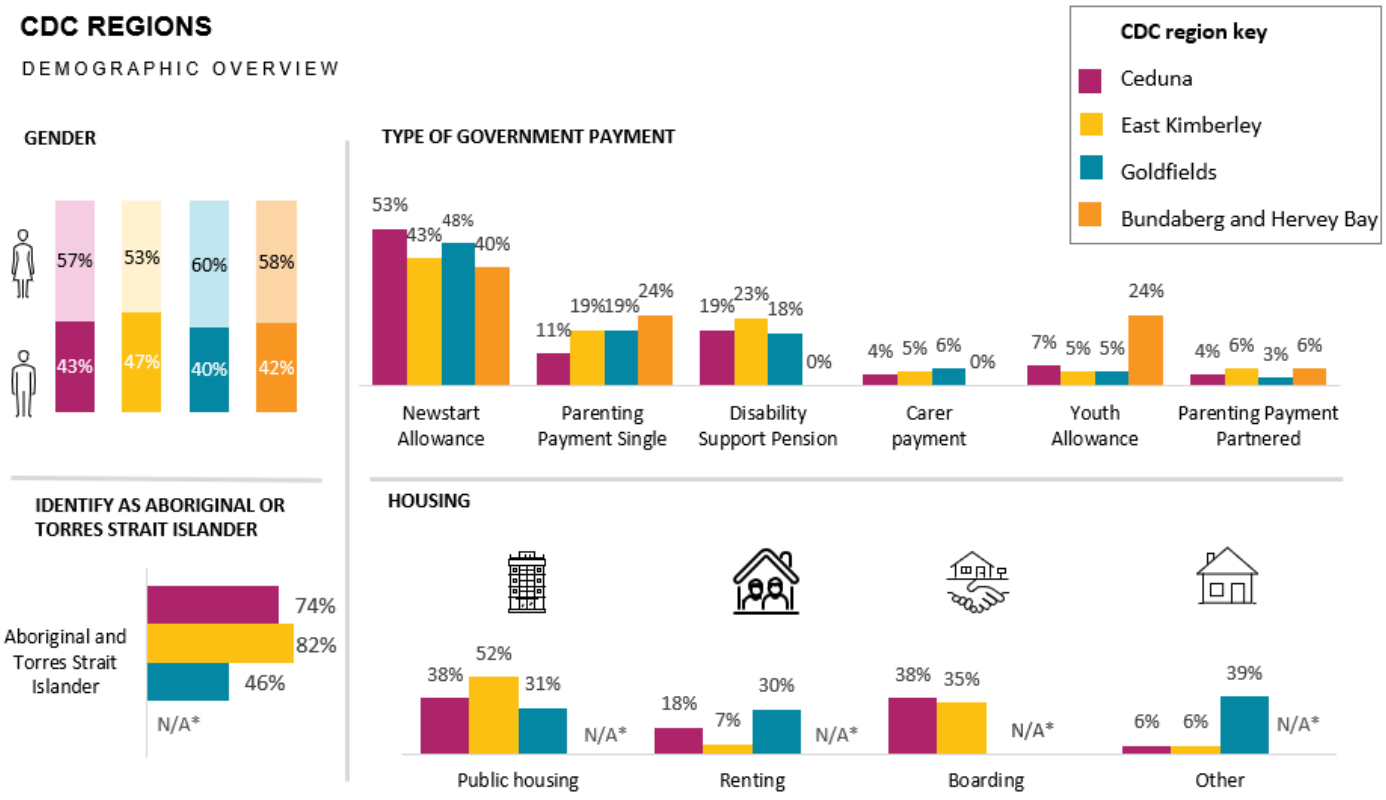


Figure 5 above provides a visual representation of the demographic information of CDC participant populations. For a full explanation of Figure 5 see Table 7 in Appendix A.

As shown above, the participant population differs in each CDC region (data accessed from the ORIMA, 2017 and University of Adelaide, 2000 reports on CDC sites[12]). The Bundaberg and Hervey Bay region has the largest number of participants involved in the CDC trial (8,061 participants) despite the eligibility restricted to those aged 35 years and younger, whereas Ceduna has the smallest number of CDC trial participants (666 participants). While the Bundaberg and Hervey Bay region has a high total number of participants, this represents approximately 6% of the

[12] The data for Bundaberg-Hervey bay region was collected at a different timepoint than the other three regions and different data was collected. Given this, there are some gaps in data about the CDC participant demographics in Bundaberg-Hervey bay region.

total population. In contrast, the CDC participant population represents a higher proportion (14%) of the total population in the East Kimberley region.

The proportion of CDC participants that identify as Aboriginal and Torres Strait Islander varied according to the region. This was highest in East Kimberley in which Indigenous participants represented a majority (82%) of those included in the trial. Similarly, Indigenous participants represented three quarters (74%) of those included in the trial in Ceduna despite one fifth (20%) of the overall population of Ceduna identifying as Aboriginal and Torres Strait Islander. While the proportion of CDC participants that identify as Indigenous in the Goldfields region is lower than East Kimberley and Bundaberg and Hervey Bay (46%), Indigenous people are over-represented in the CDC population when compared to the overall population of Goldfields (12%). This data was not collected in the evaluation of the Bundaberg and Hervey Bay CDC trial.

Reasons for engagement in the CDC trial

As discussed previously, each region has a unique socio-cultural composition and geography, with variation in community needs and access to health and AOD-specific services being diverse. Among these regions, the reasons for engagement in the CDC trial were nuanced at the community and historical level, however, there were similarities in the underlying social determinants that contributed to widespread substance use, including the complex issues of social and economic exclusion, trauma, poverty, racism and stigmatisation.

Implications for this report

Given the unique characteristics and needs of each CDC region, the consultation report will require the discussion of AOD service needs to be viewed through a local lens for each area. While we have provided an overview of similarities in AOD needs, gaps in service provision and priority areas across all four areas, it is suggested a place-based approach to grant allocation is undertaken with consideration to each CDC region's distinct socio-cultural composition, levels of AOD use and harms and accessibility of health and AOD services. It is important to note that given the high representation of Aboriginal and Torres Strait Islander peoples in Ceduna, East Kimberley and Goldfields their needs should be a primary focus.

The findings from the area-specific chapters of this report will be important evidence for that.

3. Overview of findings across four CDC sites

In this chapter, we provide an overview of the Commonwealth, state and PHN perspective of the AOD service needs of each trial site, the gaps in service provision and priority areas of focus. There exist some common themes across the areas, which point to broader issues faced by regional and remote Australia and AOD service delivery more broadly. This section draws upon the findings from the interviews with members of the Australian National Advisory Council on Alcohol and Drugs, AOD Peak bodies, relevant Commonwealth and State Government Departments and PHN interviews to provide deeper understanding of the context in which the grant funding decision-making will take place, and priority areas for consideration.

AOD Community needs in the four locations

In this section we consider the treatment needs at each of the four CDC trial sites, and the implications for allocating grant spending in each area.

Access to treatment services

In Australia, both the Commonwealth and state and territory governments play a significant role in funding AOD treatment services, with state and territory governments having primary funding responsibility. Government-funded[13] AOD treatment services are predominantly delivered by non-government service providers (69%), with the remainder delivered by governments. The access and availability of treatment services is location dependent, with significant variation between the states and territories and fewer AOD services available in regional and rural areas across Australia. According to the National Drug Strategy (2017-2026), more than half (59%) of all AOD treatment services were located in metropolitan areas, with fewer in inner regional areas (24%), remote (3%) or very remote areas (2%). According to the 'Patterns of intensive alcohol and other drug treatment service use in Australia' report (2019), individuals with AOD treatment needs who received intensive treatment were less likely to live in Outer regional, Remote and Very remote areas (15%) compared to those in metropolitan areas. This report also indicated that those individuals with AOD treatment needs who lived in disadvantaged socioeconomic areas, particularly Aboriginal and Torres Strait Islander peoples, were less likely to have received intensive treatment. These findings suggest that there is inequitable access to intensive treatment, with those living in disadvantaged regional and remote areas less likely to access the necessary treatment.

Service needs assessment

This section includes a summary of findings of the needs' assessments conducted by the PHNs of all CDC regions included in this consultation. The needs assessments conducted by the PHNs were the primary documents consulted for this brief overview, as they were available for all four CDC regions included in this consultation, and provided information at a relatively local geographical level. While we acknowledge that these findings are broader than the CDC region, they provide an overview of service needs in the wider region and information related to the context of service needs. Broader state-based needs assessment reports are also available and supplementary understanding from these reports has also been referenced here, where appropriate within the scope of this summary.

[13] Note: *The term government funded refers to federal or state funding across multiple commissioning agencies.*

Across the four CDC regions, there are similarities in the AOD service gaps and priorities, as well as service needs that are distinct and place-based. These similarities and differences are summarised below.

Access to specialist care: The PHN needs assessments identified a need for increased availability of specialist AOD services, yet there was some variation in the services identified. Both Central Queensland, Wide Bay, Sunshine Coast (CQWBSC) PHN and Country SA PHN emphasised the need for rehabilitation services, counselling and clinical care coordination services due to low service provision rates. CQWBSC PHN also identified withdrawal management as a priority area. Country WA identified the access of services that target intravenous drug use and fetal alcohol spectrum disorders as priority areas. Looking beyond the Country WA area to WA more broadly, the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (2019) noted "to meet 2025 optimal level and mix of services, increases are required across all [AOD] service streams, particularly for community support hours, community treatment and hospital-based services".[14]

Below we provide more detail about specific treatment needs and the service gaps identified in our consultation.

Aboriginal and Torres Strait Islander peoples unmet needs: Both CQWBSC PHN and County SA PHN reports identified a lack of culturally safe services within the PHN to address the high level of unmet need among Aboriginal and Torres Strait Islander peoples. CQWBSC PHN also identified insufficient Aboriginal and Torres Strait Islander AOD workers as a priority area. Country SA PHN indicated that the high level of comorbidities with mental health and/or other health problems adds to the complexity of treatment. All PHNs identified Aboriginal and Torres Strait Islander peoples' needs as important to be addressed in all areas of health disparity.

Rurality / Outreach: The need for increased access to AOD services in rural/remote and other underserviced areas was identified in the CQWBSC PHN and Country SA PHN reports. Limitations to the provision of outreach services was also identified in the CQWBSC PHN and Country SA PHN reports. Outreach services were not mentioned in the Country WA needs assessment in relation to AOD services.

Coordination of services: All PHN reports identified the need for improved integration and connectivity between the the AOD sector, health and mental health sector and other human services. This was related to the high comorbidity of mental health conditions with AOD problems, as well as recognition that poor coordination and referral processes prevents a structured stepped care approach and negatively impacts outcomes among those with AOD treatment needs.

Early intervention: CQWBSC PHN and Country WA PHN reports highlighted the need for a focus on early intervention, with both PHNs prioritising brief intervention and screening rates among GPs. Country WA also identified education as a need, as well as early intervention for those who present in hospital or emergency departments.

Workforce development: All PHN reports identified workforce development as a critical gap for service delivery, particularly in rural and remote areas. While workforce needs were discussed generally, the Country SA PHN emphasised the high demand for Psychologists, however this is set in the context of a broader need for staff across many levels in the Ceduna area. Amongst a wide range of challenges facing the sector the WA Mental Health Commission (2020) Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020-2025 also

[14] The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (2019) report includes modelling for the Goldfields and Kimberley areas of the optimal levels of AOD services. This modelling will be a useful resource when discussing grant funding decisions in these areas. The report [updated] published in 2019 includes actual service provision as of 2017, therefore it will be important to consult directly with the WA State government during the grant allocation process to access the most up-to-date information on the current provision of AOD service compared to the 2025 optimal levels.

highlights the broader challenges facing remote and rural WA including shortages of experienced/ knowledgeable AOD nurses and addiction medicine specialists.

Targeted services: All PHN reports identified a need for AOD services that target specific high-risk cohorts to ensure access to appropriate services. Youth was of particular concern among all PHNs given the high prevalence of AOD use across young people and minimal AOD services that target this cohort. Both CQWBSC PHN and Country SA PHN also identified Aboriginal and Torres Strait Islander peoples as a priority cohort. The Ex-offender group is another priority identified by CQWBSC PHN.

Modalities of treatment

As part of the context for this consultation report it is useful to consider the types of treatment delivered in each of the four CDC trial sites. For reasons of broad comparability, the figures used here have been sourced from PHN-level data. However, we acknowledge other sources exist in each state. The purpose of this summary is to provide insight into variation between Country SA PHN, Central Queensland, Wide Bay, Sunshine Coast PHN and Country WA PHA. Further detail on the services provided in each CDC trial site is included in the area-specific sections of this report.

According to the Alcohol and Other Drug Treatment Services in Australia Annual report (2021), counselling was the most common treatment type provided to all individuals with AOD needs in Australia (37% of all treatment episodes) and across all PHNs during 2019-20. This was highest in Country WA, including both the Goldfields and East Kimberley regions, with most (80%) of the AOD services providing counselling as the primary treatment (compared to 50% in Central Queensland, Wide Bay, Sunshine Coast and 42% in Country SA).

The AIHW report (2021) found that rates of support and case management were lower in all three PHNs (Country SA 9%; Central Queensland, Wide Bay, Sunshine Coast PHN 4%) than the national average (16%), with minimal rates in Country WA (2%).

Rates of rehabilitation were relatively consistent between PHN's (Central Queensland, Wide Bay, Sunshine Coast PHN 6%; Country SA 5%; Country WA 4%) and this was aligned with the national average (6%). However, there were fewer treatment episodes that supported individuals with withdrawal management in Country WA (3%) and Central Queensland, Wide Bay, Sunshine Coast (4%). Country SA (9%) was consistent with the national average (9%).

Central Queensland, Wide Bay, Sunshine Coast PHN was found to have a high number of information and education approaches (24%) compared to the national average (7%), whereas this was minimal in Country SA and WA (2%). Accessibility of treatment modalities in each CDC region is discussed further in the "current provision of AOD treatment services in the four locations" section.

It was important for this report to include reference to the current published information in each of the CDC regions included in this consultation. The review of this information has provided a foundation to our understanding of the current provision of services, and where there are shared challenges; such as in access to workforce, provision of outreach, and early identification of problematic AOD use.

Challenges presented by COVID-19

COVID-19 has led to a change in the types of issues prevalent in each of the communities. For example, during the pandemic it became easier to access alcohol, with home delivery becoming more available, and alcohol-based hand sanitiser widely obtainable, sometimes without charge. It also led to greater societal change and pressures that will have shaped the social determinants of health for those seeking treatment for AOD use. Social distancing requirements have impacted face to face service delivery during the pandemic, and treatment services have had to make many adjustments to their service delivery approaches to continue providing treatment to their clients. The additional pressures should also be considered in any grant funding allocation, as they will have created greater demand for services and exacerbated the challenging environment in which healthcare professionals are operating.

Barriers to treatment

This section looks at the barriers for individuals with regards to seeking and accessing AOD treatment services in the four CDC trial sites. It is important to note that a greater volume of barriers were found in access to treatment, rather than related to an individual's actions to seek treatment. These barriers were noted by stakeholders as existing to varying degrees across the four regions and are not in any particular order.

Perception of social stigma and a sense of shame: Concerns relating to the stigma and shame associated with accessing AOD treatment services was noted by several stakeholders. Across all four CDC trial sites, issues were raised around social stigma related to challenges with AOD use and worry about discrimination that might ensue once associated with treatment. This was identified as a particular barrier in the outer regions of the four areas, as there was concern that it may not be possible to receive AOD treatment anonymously. It is also relevant to note the perceptions of social stigma and shame associated with being on the CDC, which presents its own barrier to help seeking.

Lack of understanding of the services available and how to access them: Many individuals in CDC sites who require access to AOD treatment services lack familiarity with services available or the pathways to gain access. This can present a significant obstacle for treatment.

Location of appropriate treatment types: Each of the four CDC trial sites service large geographical areas. From 3,818 square kilometres for the Bundaberg and Hervey Bay region to 771,276 square kilometres in the Goldfields region, remoteness was identified by stakeholders as a primary barrier for many when seeking AOD treatment.

Outreach programs present a solution to the barrier of remoteness; however, continuity of staff and the timing of outreach services can lessen their impact. These two aspects are important when service providers are seeking to build trust and encourage people in the outer regions to engage with treatment services.

Lack of local infrastructure in remote communities: Several stakeholders reported that a lack of infrastructure outside of the community centres presented a barrier to receiving appropriate treatment. Transport was noted as a significant challenge, especially transport to and from the more remote communities within the regions. Public transport (such as bus services) are often infrequent, unreliable or non-existent, making it challenging for individuals to get to AOD treatment services. Lack of accommodation for staff was also identified as an infrastructure, and barrier to workforce growth and retention in each area.

Access to culturally safe services: While each of the sites has a unique combination of AOD treatment services, as previously outlined, the mix of available services can be a barrier for some. Specifically, a lack of culturally safe services also leads to a lack of trauma-informed provision of care. For example, in the Goldfields region there is no specific Aboriginal and Torres Strait Islander managed service, which is a barrier for those seeking a culturally safe treatment option. However, it was also identified that the definition of culturally safe needs to be led by the individual seeking treatment and making available the best possible package for that individual is important. The ability to design the treatment around the needs of the individual is considered to have a clear relationship with positive outcomes.

Role of collaboration and system capacity: Some stakeholders identified the benefit that greater capacity in the system to create space for multi-disciplinary teams to support patient needs. Where a lack of capacity existed, it was felt there is less time to support more complex treatment needs alongside AOD treatment such as chronic homelessness, complex mental health issues and behavioural challenges.

Staffing shortages, recruitment and retention: Workforce recruitment and retention was raised as an ongoing issue across all four CDC trial sites. This was presented as a crucial barrier to be overcome before AOD treatment could be expanded, and alternative approaches such as outreach be considered. As noted previously, sufficient

accommodation for the workforce is also an important element of recruitment and retention, which will need to be addressed should the grant process seek to increase the size of the workforce at a specific location.

Current provision of AOD treatment services in the four locations

Existing AOD services

During the consultation information about the current provision of AOD treatment in each of the four regions was sought. Discussions took place on the broad provision and need for services, which has informed the content of this report. Lists of services funded by the Commonwealth and state governments, the NIAA and PHNs were also supplied.

The purpose of the provision of these lists was to provide guidance as to the current provision for each CDC region, and a reference point for the consideration of the funding of additional services, in particular for additional funding for services currently in place. A compilation of the information generated during the consultations is provided in the appendices. These lists provide general guidance to the range of AOD treatment services provided in each area, and are not designed to present an exhaustive review of the provision of AOD treatment services in each region.

Residential treatment

Residential rehabilitation is only available in two of the four CDC trial sites included in this consultation. That is in Wyndham for residents of East Kimberly, and in Kalgoorlie for residents of the Goldfields area. The Queensland state government has committed to build a new adult residential rehabilitation facility treatment service for those in the Bundaberg Hervey-Bay region; a 28-bed rehabilitation facility, which will have 20 rehabilitation beds and eight withdrawal beds. However, there is no residential rehabilitation facility (and currently no plans for one) in Ceduna. For Ceduna, there is a day centre run by an ACCO (Aboriginal Community Controlled Organisation), ADAC, but those that require longer stays would need to travel 470km to the nearest overnight residential rehabilitation centre, with most services located in Adelaide (approximately 9-hour drive).

Despite the broad geographical coverage of the Goldfields and Easy Kimberley regions, there were similar numbers of residential rehabilitation services within the surrounding areas. However, it is important to note that geographic and weather conditions create specific challenges for travel for treatment among those located in the East Kimberly region in particular, with the risk of cyclonic seasons preventing movement.

Some residential rehabilitation services require those referred to the service to completely abstain from AOD use. However in Ceduna, specifically, there was mention from stakeholders of the possible benefit of a residential treatment service with less focus on sobriety, but the creation of a space to stabilise AOD use, provide access to employment programmes, or education programmes, and support the transition back into the community.

There are sobering-up centres in four locations in the Kimberley, and one in the Goldfields; an overnight facility for people who are highly intoxicated. And, in the Goldfields there is one residential facility, which includes a withdrawal service.

While residential rehabilitation is not universally accessible at each of the CDC trial site locations, which was identified as a barrier for a person-centred approach to treatment; the time required to locate a site, build a facility, and recruit and train a workforce were raised as key concerns by stakeholders when asked whether they should be considered for grant funding.

Outreach

The provision of outreach services was provided to some degree at each trial site; however, it was felt that more could be made available if qualified staff were included. It was noted that a benefit of outreach can be breaking down barriers between service providers and those requiring treatment and enabling the building of trust. This was particularly noted where person-centred, culturally safe outreach services were available.

For example, each of the regions in WA has a community alcohol and drug service (CADS). This is an outpatient prevention, outpatient counselling and diversion programme provider that works across the whole region. With one in the Kimberley and one in the Goldfields, they provide individual counselling, support for families, prevention services and diversion services. They operate from central offices and from those offices they provide outreach to smaller councils or remote communities.

An additional example of building trust and making services available directly to individuals is in Ceduna where the Aboriginal Drug and Alcohol Council SA (ADAC) has a day centre, which provides breakfast for local people. By attracting individuals to the centre, they can also arrange for the ambulance service to attend to perform triage of things such as minor wounds, and treat basic health issues like scabies, or infections.

Case management

AOD treatment and support at each of the trial sites is delivered both in isolation and alongside broader social support such as mental health support, financial budgeting, or family support and parenting. The cross-over (albeit not universal) between AOD treatment and mental health support has led some agents to design initiatives that aim to benefit both, for example the Boab Health Services ABLE initiative in East Kimberly. The program includes building personal resilience and supporting participants to sustainably manage the impacts of their mental health issues, including issues with drug and alcohol use.

In Queensland there have been efforts to use a case management approach to tackle physical health issues, AOD use, mental health and wellbeing, and quality of housing. It is acknowledged that this is a very challenging area as people's lives can be complicated. However, the grants program could have a role in supporting a case managed approach for the delivery of broader long-term positive health and social outcomes.

This addresses the barrier identified in a previous section of the desire to design treatment around the needs of the individual. Stakeholders emphasise that where this does not happen it is due to resource and capacity challenges.

Counselling

As mentioned previously counselling services currently make up a high proportion of the AOD treatment across CDC trial sites. However, in some areas it is felt that demand outstrips supply, and that access to a suitably qualified workforce presents challenges in ensuring that outreach teams have appropriate access to qualified psychologists and other clinicians in the provision of counselling.

It is important to consider the environment in which counselling is delivered however, as it is possible for supply to outweigh demand in environments where those who might benefit from treatment do not subscribe to what is offered. It will be essential that the grant allocation considers local insight, from this consultation, and more broadly before making investment decisions to ensure the context in which services are offered will meet the needs of local people.

For example, covering the Goldfields and East Kimberley regions there is specialised outpatient counselling that specifically targets Aboriginal and Torres Strait Islander peoples. There are three providers, including in Broome and Wyndham.

Prevention-focused community-led activities

The consultation identified that increased prevention activities were required in all areas.

In prevention as noted in relation to treatment, the demand for community-based activities is closely aligned to a demand for service providers to be supported to work well together to ensure that an individual can benefit from services delivered by multiple-disciplinary teams, without needing to approach and engage with each organisation in

isolation. The resources for place-based networks offering a range of services was highlighted as a mechanism of delivering treatment via multi-disciplinary teams in each community.

Organisations such as Empowered Communities in East Kimberley and Ceduna have a deep knowledge of the history of work undertaken in this area. They therefore have an important role to play in representing the perspective of local people and ensuring their needs and those of the areas as a whole are considered. Local self-determination was raised as essential for positive outcomes in AOD treatment and interventions.

As noted previously, in East Kimberly and Goldfields there are Community Alcohol and Drug Services (CADS) teams responsible for delivering non-residential services and they liaise with WANADA via health regions to feed intro strategies and policy planning. This delivers some level of bottom-up input to the design of community services.

However, stakeholders also mentioned one-off examples worth considering for future funding at each site. For example, initiatives such as 'hub-days' where service providers collaborate, bringing together for example Centrelink, mental health services, and family support services in situations and contexts where the community gathers and where individuals could be offered support by multiple service providers depending on their need.

In another example, reflecting on the potential of bottom-up design from a foundational community level, in WA there are examples of community-led AOD educational programs. The community might decide that it wants to reduce the acceptance of alcohol among young people, and might decide to insist that all the sporting events are alcohol-free. In that scenario the community drugs service team would provide support with campaign materials, and community liaison, or perhaps record a film in language. There are also local drug action groups, where interested community members can get together and apply for small grants, to do community activities.

Provision of services targeting the needs of key groups

Most AOD services did not specify a target audience. For those that did specify target cohorts, AOD services targeted Aboriginal and Torres Strait Islander peoples, young adults, culturally and linguistically diverse or gender-specific services.

Gender: There were few treatment services that catered specifically to women seeking AOD treatment. Stakeholders mentioned a desire from some in the community for women-only treatment options. This indicates a role for women-specific services, for women in general and those experiencing family violence for AOD treatment.

Youth: Although there were few treatment options designed solely for youth, stakeholders emphasise the importance of ensuring that those working with youth understand the 'soft entry points' for directing young people to treatment. For example, a young person might present to Centrelink experiencing problems, which they receive help for, and while receiving that support they disclose that they are also having problems in school, and that they required AOD use support. The benefits of ensuing that the variety of 'soft entry' points are supported to ensure that young people can be offered the services they need was felt to be an important direction for funding.

Culturally safe: Culturally safe and appropriate treatment services for Aboriginal and Torres Strait Islander peoples were present in East Kimberly and Ceduna, however this was less common in the Goldfields or Bundaberg & Hervey Bay regions.

Stakeholders involved in this consultation mentioned that consultations had previously been conducted, particularly in the Kimberley, around the importance of service models that are Aboriginal and Torres Strait Islander led, with a focus on family, community and culture. These Stakeholders expressed the need to look at a cultural model of service for AOD treatment, however, they also acknowledged the challenges that service providers can face when tasked with providing a service that is homogeneously deemed "culturally safe and appropriate" to all, because it is essential that individuals are given the opportunity to determine whether they believe a service is culturally safe.

Further to this stakeholders noted that measures must be put in place to guide mainstream services to be culturally safe and appropriate[1516].

[15] WAPHA is developing a Cultural Competence and Capability Framework that will provide a guide for all commissioned service providers regarding expectations and how these will be assessed

[16] It is also important to note that a key commitment of all Australian governments as part of the National Agreement on Closing the Gap - ref: Priority Reform 3 is that improved cultural safety leads to improved health outcomes.

Gaps in current service provision in the four locations, and how these might be filled

This section provides an overview of the Commonwealth, state and PHN perspective on the observed gaps currently present in the provision of AOD services across the four CDC trial sites and suggestions for how these gaps could potentially be filled.

Gaps in the provision of treatment services

Stakeholders noted that despite best efforts by all parties, there are gaps in the provision of AOD treatment services across all four CDC trial sites. Some of this content has already been touched on earlier in this report so this section seeks to expand on this and outline specific gaps in the current provision of treatment services.

Insufficient services that are considered to be truly culturally appropriate and safe: Stakeholders noted that while there are current services in East Kimberley and Ceduna that operate in culturally appropriate and safe manner there is more demand than can be provided for, and these types of services are not currently present in the Goldfields or Bundaberg Hervey-Bay regions. In general, there is a lack of services that are led by Aboriginal and Torres Strait Islander peoples and culturally respectful of different ways of living and worldviews.

Insufficient outreach services: While outreach services were noted as experiencing greater demand than could be met across all four CDC trial sites, stakeholders also acknowledged the challenges associated with its provision. These challenges include building and maintaining trust with those living in remote communities, access to the remote areas within the regions, services being delivered in an appropriate way for the communities in the outer areas of the regions and continuity of care.

It was noted that while these challenges are known they are not insurmountable. Stakeholders would like to see more action to overcome these challenges. Examples of how this could be done are included later in the chapter under the heading “How to fill the gaps”.

Insufficient services that are designed for Women and Families: Across all four regions, women and women with children were noted as having insufficient AOD treatment services tailored to their needs. It was noted by many stakeholders that the needs of this group are different from the mainstream, and require a tailored approach.

Insufficient services aimed at and designed for Youth (under 25): Youth were another group that were considered to be underserviced across the four regions. The issue was considered particularly relevant in the Goldfields and East Kimberly[17] in particular, where stakeholders identified youth access to AOD and mental health treatment as representing a specific gap, where currently the solution is to travel to Perth for treatment or to call the Flying Doctor service for an acute response.

Current workforce capacity to meet AOD treatment needs: peer delivery, local service delivery: As mentioned previously there is concern about workforce recruitment and retention in all four CDC trial sites. However, stakeholders also spoke of the qualifications gaps in the sector more generally. While the benefit of peer support was recognized, it was felt that this should be supervised and supported by clinically trained professionals, but currently there is a gap in availability of professionals to build capacity and support those working in the sector. This will also be a challenge for any grant funding that attempts to start a new service, or add funding to a current

[17] Note: a headspace centre is due to open in Kununurra in 2022

service. All stakeholders emphasised the importance of associating any grant funding with capacity building, training and making the CDC trial sites as desirable as possible for qualified professionals to travel to.

The cost of housing for qualified professionals relocating to a CDC trial site region was considered either prohibitive, or the housing itself unavailable, presenting another challenge for the development of a grant funding process aiming to attract workforce to an area.

It was also noted that the time-limited nature of grant funding presented an issue when trying to attract a workforce to an area, further emphasising the need for funding to be used to build capacity and support the training and qualifications of local people, to deliver positive outcomes in AOD treatment in the longer term.

Infrastructure gaps: The challenge presented by a lack of infrastructure is a complex issue, with the motivation to use AOD not occurring in isolation. The access to infrastructure and services in regional and rural Australia was a topic mentioned in every stakeholder interview. This related to access to AOD treatment services, but also broader social determinants of health. The World Health Organisation describes these as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[18]"

Stakeholders acknowledged that service providers cannot (or at least should not) address AOD issues without also addressing basic needs, such as food and shelter. In all four regions stakeholders mentioned a demand for greater access to employment, training and housing as essential for working alongside AOD treatment services in each area.

Although it was recognised that more AOD treatment could be beneficial at each CDC trial site, stakeholders noted the need for further funding to address the barriers created by the social determinants of health. It was suggested that this would create an environment where someone receiving treatment would be better supported to maintain new habits and healthy behaviours. The potential for this round of grant funding to contribute to this goal, and others such as a package that includes the Department of Social Services Jobs Fund, should be considered.

How to fill the gaps

In the interviews with stakeholders, suggestions were made on the ways in which the gaps identified may be filled. These are summarised here and will be considered alongside the broader reflections on community needs in the recommendations section of this report.

Greater levels of collaboration: Resources to increase the capacity for partnerships between AOD treatment services and multi-disciplinary teams of other local health service providers, such as family and domestic violence services or homelessness services. To be successful, consideration will be required of how to support the current workforce to achieve this, and attract new workforce members.

Local engagement: With the importance of the involvement of local communities and those with understanding of the needs of the local community, there was a desire for gaps in services to be filled where possible by community-controlled organisations with a focus on providing culturally safe/appropriate services, which are of benefit not just to Aboriginal and Torres Strait Islander peoples but other groups throughout local communities. This was also associated with a desire for increased outreach service provision to the community, and building the capability of individuals like community brokers, who support the development of trust between individuals who need treatment and service providers.

[18] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Training and capacity building: With the challenges faced with workforce recruitment it was recommended that attention be paid to training and building capacity among local people and organisations, including organisations led by Aboriginal and Torres Strait Islander peoples.

Guidance for the development of a grants programme

Maximising the potential of local service providers

The rules governing the submission of grant funding tender responses often require respondents to comply with appropriate quality standards processes and have specific insurances. The format of the tender submission process also requires the organisation to have one or more people who have the skills to articulate their proposition in a clear way for external review. This process may exclude some organisations who struggle to meet any of these requirements.

However, this could be mitigated if there is a requirement that those responding to the tender consider the ways in which they will build capacity and/or meaningfully engage with the local community in the delivery of their service. if they can form a true partnership or collaboration with one or more other service providers in the area they would be able to not only apply for the funding, but the community would be better off for this, as the services would be more inclined to be working together and thus potentially providing a more holistic style of treatment.

For example, in a specific tender process that the WA state government is currently running, submissions are required to demonstrate that they're going to build the capacity of local organisations, working as a consortium, incorporate working with peers and mentors. The expectation is that by including this requirement that the knowledge and skills of local service delivery specialists will be included, but also that local knowledge and networks will be galvanised to contribute to positive outcomes for individuals.

There is also a desire to consider the potential of grant funding to build the capacity and skills of local people, by requiring the training of local people, and knowledge sharing with local organisations to be included in the design of an application.

Ensuring decisions are informed with knowledge from the local area

In our interviews with stakeholders the importance of tailored solutions was stressed. This was in terms of a greater focus on a client-centred approach to treatment and reflections on the way that all aspects of life – education, housing, mental health can be included in a treatment plan. But it also included ensuring that local community needs and local AOD funding bodies are included in the decisions over which grant submissions are approved. This included the NIAA and Empowered Communities representatives from Ceduna and East Kimberly.

The benefits of co-design of solutions and co-delivery of services were also recognised, with an important role for established local community led partners in any bids. Community partners will be able to highlight the findings from existing AOD regional plans, further ensuring that funding is complementary to existing strategies in place. It was also noted that the Closing the Gap National Agreement - Priority Reform 2 - build the community-controlled sector, and Priority Reform 1 - formal partnership and shared decision making with Aboriginal and Torres Strait Islander peoples require adherence; which would lead to the inclusion of Aboriginal and Torres Strait Islander led organisations in decision-making.

Ensure the length of funding allows for a significant contribution

Stakeholders stressed the challenges faced in acquiring and retaining staff when the funding is short-term. While there was desire for funding for a period of greater than four years, the challenges associated with this were acknowledged. Therefore, where it is known that funding will be available for a four-year period it would be preferred that the grants are allocated for the full period and not broken down further.

Potential issues with implementing grant funding and how to avoid these issues

Avoiding duplication: By reflecting on the findings in this consultation and ensuring that state-based and local AOD funding bodies are engaged during the award decision-making process it will be possible to ensure that the services funded will have maximum benefit for the local community. This could also deliver benefits in reduced administration for those submitting grants by enabling information-sharing between Commonwealth and state-based commissioners and aligning reporting requirements and deliverables.

Recognition of the power but also the pitfalls of evidence-based KPIs: While it was recognised by stakeholders that evaluating the impact of services was important, it was also considered important that their use should be sparing, and more sophisticated evaluation measures should be used to avoid 'delivery to the data'. It was felt that over-use of KPI metrics could lead to a focus of energy on what is measurable rather than what will have the strongest impact on treatment. Therefore, it was recommended that a balance be found when setting evaluation criteria, with greater use of outcomes or impact-based reporting.

Recognition that the grant funding will come to an end: When considering the award of grants, stakeholders felt that a transition out plan would need to be considered. This led stakeholders to preference pilot initiatives or additional funding for current services to maximise the time in delivery and minimise the impact when the funding comes to an end. Stakeholders recognised an inevitability in the time-limited nature of grant funding, but would prefer longer timeframes, such as 7-years in future. The longer timeframe enables the development of more enduring relationships with the workforce and local community.

Stakeholders stressed that AOD treatment needs in each region will require additional investment into the foreseeable future. The treatment of AOD use is an ongoing process of community development, which requires more time than that available in a 4-year grant. Long-term investment is required to undo transgenerational trauma caused by colonialism, stigma, family violence, disengagement, and lack of access to education, training and work among other social challenges.

As noted in feedback to this report from the national authority on Aboriginal and Torres Strait Islander comprehensive primary health care, The National Aboriginal Community Controlled Health Organisation (NACCHO), grant funding should be delivered in line with the approach agreed and signed by the Australian Government in The National Agreement on Closing the Gap.

4. Ceduna - Perspective of local stakeholders

Community AOD needs

Main social and health issues, and specific AOD issues: Several social and health issues specific to AOD use were raised by local stakeholders in Ceduna. Excessive alcohol consumption and public intoxication were mentioned.

> *"…we do have a complicated relationship with drug and alcohol issues in Ceduna, like any medical practice we do experience drug seeking behaviours, we witness intoxicated people."* (Mainstream Health Provider, Ceduna)

Other issues expressed by local stakeholders included the sentiment that there were no meaningful activities around Ceduna for people who are visiting the town. It was also reported that people who visit Ceduna from the surrounding remote communities, engage in 'excessive drinking' while in town, and are then unable to board the bus back to their communities. This, combined with irregular transport services to remote communities overall results in people being 'stuck' in Ceduna, increasing the likelihood that they become caught in a cycle of excessive AOD use.

> *"…the fact that we've still got a big transient population, that influx the town, we're a regional centre, pretty similar to Port Augusta and Alice Springs. We would have a number of surrounding communities and people traveling to the community, and adequate accommodation is always hard to find, but also the right sort of assistance and when it comes to drug and alcohol support."* (Aboriginal Community Leader, Ceduna)

Related to AOD issues in Ceduna, problems with police intervention were also expressed. In particular, local stakeholders expressed concerns around an increase in police arresting intoxicated Aboriginal people as a consequence of the reduced hours of the local Sobering Up Unit.

Gambling and family violence were also mentioned as major social issues in Ceduna.

> "*…As a Ceduna community member, addiction, family and other violence, it also ties into gambling activities because I guess probably the main part of our town, the Ceduna hotel is like primary access and the 'Bottle O' attached to that is primary access to alcohol and as a part of that they have a really large gaming venue and that can be sort of a meeting place for people with issues with alcohol. That's probably all I can really say from my perspective.*" (Mainstream Health Provider, Ceduna)

Another significant health issue voiced by local stakeholders was AOD use during pregnancy.

Perceived drivers to uptake of AOD treatment: Perceived drivers to uptake of AOD treatment included the Sobering Up Unit (run by a local ACCHO), Aboriginal Drug and Alcohol Service Day Centre, and Mobile Assistance Patrol where people who are regularly engaging in these services are provided a referral for AOD treatment.

Perceived barriers to uptake of AOD treatment: Some barriers identified by local stakeholders included:

- No local rehabilitation or detoxification service;
- Local perceptions of the Sobering Up Unit enabling AOD behaviours;
- Community stigma towards AOD use impacting help-seeking behaviours.

Community attitudes to AOD services

Community attitudes to AOD services in Ceduna, as voiced by local stakeholders, indicated that, particularly for Aboriginal peoples local to the Ceduna area, it is felt that AOD services are not catered specifically for them and culturally safe.

> "*There's too much services…need to be targeted…from the local Aboriginal point of view from people in Ceduna is them services are only there for the Anangu mob...the Aboriginal people who've lived in Ceduna all their lives are missing out…it's even drawing health services away from the local community…*" (Aboriginal Community Leader, Ceduna)

Mobility of people in need of AOD treatment: Ceduna is considered a regional hub and receives many visitors from the surrounding areas. Aboriginal community members often travel from the surrounding remote communities of Scotdesco, Yalata, Oak Valley and Tjuntjuntjara to Ceduna.

In particular, it was outlined that residents of Oak Valley (approximately 8 hours drive from Ceduna) frequent Ceduna to access various government and NGO services in the town including AOD services provided by Yadu Aboriginal Health Services, Stepping Stones Day Centre and the SA Health Ceduna Hospital's Step Down Unit located within the hospital precinct.

However, given that there is no specific rehabilitation or detoxification centre in Ceduna, people in need of these services must travel outside Ceduna. Specifically, people are referred to the Footsteps Road to Recovery Residential Rehabilitation, run by the Aboriginal Drug and Alcohol Council in Port Augusta, approximately 5 hours' drive from Ceduna.

Features needed to make an AOD service culturally safe and appropriate for Aboriginal and Torres Strait Islander peoples: The main suggestion across the interviews in Ceduna to make an AOD service culturally safe and appropriate was by employing Aboriginal staff. Local stakeholders also expressed that it was particularly important for services to be specific for specific Aboriginal cultural and language groups as different groups have different cultural needs and cultural protocols. One Community Leader highlighted the importance of services being Aboriginal led.

> "*it can't be government driven…it needs to Aboriginal led. So, there are also the Aboriginal leaders here, maybe they're the ones who need to step up and say more like what are the best strategies, what are the best cultural ways to be able to work with them fullas who have addictions in drugs and alcohol*" (Aboriginal Community Leader, Ceduna)

It was also considered important for AOD services to provide a range of activities that are culturally based for Aboriginal people, such as spending time on Country, and engaging in other specific social and cultural activities.

In addition, it was considered essential that cultural safety and appropriateness of AOD services must go beyond cultural awareness training, but implement community consultation and local knowledge in the delivery and implementation of AOD services.

Current provision of AOD treatment services

Existing AOD services and reach - both within and outside the local area: Several existing AOD services were mentioned by local stakeholders in Ceduna, including the Drug and Alcohol Services South Australia (DASSA) based at the local hospital, where medical assistance can be provided for people who are unwell due to excessive alcohol consumption or drug use. In addition, services run by ACCOs were also mentioned, including the Sobering Up Unit run by Yadu Health Aboriginal Corporation, and the Stepping Stones Drug and Alcohol Day Centre run by the Aboriginal Drug and Alcohol Council.

> "*We have Drug and Alcohol Services SA who work for the hospital here, they have an office in the Ceduna District Health Services…we've got a Red Cross in Ceduna which provides a lot of support. We have CentreCare, these are also services located in the middle of the town centre so they're easily accessible to people*." (Mainstream Health Provider, Ceduna)

Some local stakeholders also perceived dry zones and the introduction of the CDC as other ways to curb AOD use, though the CDC is understood to be an experimental and contentious tool that evokes mixed perceptions across local stakeholders.

> *"The only thing that I have witnessed, attempting to address it, would be the alcohol restrictions that are in place in Ceduna. So dry zones, limited number of specific alcohols that can be purchased in Ceduna and quantities. And I guess the cashless debit card was introduced as a way to, as an experimental way to address it, as well."* (Mainstream Health Provider, Ceduna)

> *"...With the debit card came a lot of support services, so we've been able to make sure that there's a number of supports in that process as well…a lot of funding coming into the region…just sort of recently, we're able to have a bit more community…it's important that we all keep each other accountable in the process and make sure that we're getting 'bang for our buck'…"* (Aboriginal, Community Leader, Ceduna)

Outside of Ceduna, local stakeholders mentioned that people may be referred to the Footsteps Road to Recovery Residential Rehabilitation, run by an ACCO, as mentioned above.

Other types of support used in AOD treatment: Other types of support for people identified by local stakeholders included:

- ***Transport assistance:*** the Mobile Assistance Patrol, is an active outreach program in and around Ceduna, which provides transport for intoxicated people to the sobering up unit, medical services or a safe environment.
- ***Family Support*****:** a success highlighted by an ACCHO representative in Ceduna was the role of Aboriginal families in providing AOD support. This individual explained that Aboriginal residents of Ceduna, with local family members, are not using the Sobering Up Unit, ""If they get drunk, their family takes them back home".
- ***Country connections:*** Country Connections is a program run in partnership with the Aboriginal Drug Alcohol Council which provides on Country diversionary activities for Aboriginal peoples sleeping rough and living with AOD issues in Ceduna. Specifically, Natural Resources Alinytljara Wilurara (AW) staff take people out from the Ceduna day centre to assist with the Natural Resources Management project works being undertaken in the Southern AW region.
- ***Human Services:*** local stakeholders mentioned other types of care services which they colloquially referred to as 'The Care Bears', these organisations included CentreCare and Red Cross, who provided social support, for example, assisting with providing housing.

Success with current AOD approaches: Successes with current AOD approaches that were outlined by local stakeholders included the Sobering Up Unit, which provides a place to sleep and a light breakfast to clients utilising the service. Another success was the accommodation facility in Ceduna, called a 'town camp' run by South Australian Housing where all Aboriginal people who require short-term accommodation or assistance can stay.

The Mobile Assistance Patrol was seen as another successful AOD approach, as it was felt that this transport service specifically addresses some of the community concerns around public intoxication and police arrests, by providing intoxicated people with safe transport within the township.

In particular, local stakeholders expressed that in general, the most successful AOD approaches were those that had high community engagement in the design phase.

> "*…The ones that we have had the most success is when we've been able to grow from a grassroots level where we engage with the community, your relationships, not tried to tell them that they have a problem or what they should be doing about it, but really from a very much a supportive and natural point of view. Just engaging with people and allowing them to decide how they want to be, able to take a sense with some guidance from qualified professionals*." (Aboriginal Community Leader, Ceduna)

In addition, those AOD services with a holistic approach were also identified as particularly successful:

> "*…And it's not just approaching it as a specific AOD issue, so when we've had social emotional wellbeing workers involved as well as AOD workers as well as counsellors, and as well as support workers in a combined approach*." (Aboriginal Community Leader, Ceduna)

Challenges with current AOD approaches: While the Sobering Up Unit was identified as a successful AOD approach, local stakeholders reported that it was recently faced with funding cuts and is now having to operate at reduced hours. Concerns were also expressed around the strict criteria to be admitted to the Sobering Up Unit, where intoxicated people must register a specific figure on a breath test to be admitted to the unit, with those registering below that figure being turned away.

Some local stakeholders raised several concerns associated with the Sobering Up Unit program itself. These concerns revolved around the idea that the unit was not directly helping people with their AOD use, with some community members believing it to be enabling AOD use.

> *"You've got the Sobering Up Unit there…We had to give that process up because it's not really helping our people. It's just providing them with a Bed and Breakfast sort of thing, shower and clothes…"* (Aboriginal Community Leader, Ceduna)

> *"…Don't know if it's an excuse for them to get drunk so they can get in the Sobering Up Unit, they get a bed for the night…and the cycle continues.*" (Aboriginal Community Leader, Ceduna)

Current workforce capacity - peer delivery, local service delivery: Local stakeholders' opinions on current workforce capacity highlighted the difficulties of attracting qualified health professionals to Ceduna, as well as staff burnout.

> "*…and all service providers, I think we always challenged with attracting people into small communities.*" (Mainstream Health Provider, Ceduna)

> "W*orkforce burnout is a big problem across rural and remote Australia, South Australia in particular. So you may very well have a service existing, but having the appropriately skilled workforce to be able to deal with the issues, I think is probably one of the biggest challenges. And I don't think anybody's got that mix right*." (Mainstream Health Provider, Ceduna)

Cultural safety and appropriateness for Aboriginal and Torres Strait Islander peoples: Cultural appropriateness and culturally safe practices were seen by some local stakeholders as concepts that are difficult to define because of the diverse nature of different groups of people, particularly Aboriginal peoples. It was expressed that what is

considered culturally safe or appropriate is different to various groups depending on their cultural traditions, practices, and protocols, and different to different people depending on whether their first language is one other than English, whether they observe their cultural practices, and other factors.

> "*…The definition of cultural safety is different to a number of different people depending on how traditional they are, the experiences they have, what their needs are…"* (Aboriginal Community Leader, Ceduna)

Gaps and how might these be filled

Gaps in the provision of treatment services: A key gap in the provision of treatment services in Ceduna, outlined by local stakeholders, is the lack of a specific detoxification and rehabilitation centre, located within Ceduna.

Local stakeholders also expressed concerns around services focusing mainly on alcohol use, and less on drug use.

> "*Drugs [are] here, but we actually don't have a focus on drugs...because we're not equipped, we're not a drug centre, we're [an ACCHO]*" (ACCHO Representative, Ceduna)

Concerns were also raised around the lack of change and effectiveness of current interventions.

> *"…with … influx of services we are still seeing people are drunk, on the street on the street, homeless, living rough, sleeping rough all that kind of stuff. And we can't understand from our point of view, where's the change with the break in cycle and where's the intervention?"* (Aboriginal Community Leader, Ceduna)

The fact that only a limited number of men are employed in AOD support roles was also identified as a gap in the engagement of men in AOD treatment in Ceduna.

Limited mental health specific services were outlined as a major gap in the provision of AOD treatment, given high rates of comorbidity with AOD use and mental health issues.

> *"… I would say in the last two years, a third of my work…the work that should have been done by mental health. But as a nurse I can't say 'buzz off its not my job', you're a person in peril and I have to respond to that. So, I can't go on enough about the lack of mental health services here on the ground. Senior clinicians. They need to be here…"* (Mainstream Health Provider, Ceduna)

Significant concern was raised around the lack of prevention and post-treatment services. The general sentiment was that a lack of meaningful activities after people have gone through AOD rehabilitation was a key driver of AOD relapse. In addition, local stakeholders expressed that limited mental health services, considered essential to address the underlying drivers of AOD use (e.g., intergenerational trauma) was another gap in the current provision of AOD services in Ceduna.

> "*One thing that we do lack and we know we lack, is mental health services. There are a lot of underpinning issues, a lot of trauma and things that have happened over a period of time that ultimately [we] aren't able to address.*" (Aboriginal Community Leader, Ceduna)

Gaps in cultural appropriateness of services for Aboriginal and Torres Strait Islander peoples: The biggest gap in the cultural appropriateness of current AOD services highlighted across the interviews in Ceduna was the limited number of Aboriginal staff within AOD services. Local stakeholders expressed that it was also particularly important for services to be tailored to specific Aboriginal groups in the Ceduna region, as well as to ensure community consultation occurs.

> "*You arrive in a place like Ceduna…does someone grab you and say, 'ok, we're talking three different language groups, we're talking these people believe this and these people believe in that, these people are coming from this way'…that sort of cultural awareness is not being taught…and because of that we do end up setting people up for failure*" (AOD Service Provider, Ceduna)

> *"I always say for Anangu (Aboriginal groups from the Western Desert) health to improve, we need trained Anangu talking with Anangu."* (ACCHO Representative, Ceduna)

One Community Leader also felt that there was a lack of consultation of Aboriginal Elders in regard to the development and delivery of AOD services.

> "*What's the approach? I don't think we know what the answer is we've got our ideas…to be truthful go back with our Elders let's give them that respect. With the way oppression and racism and everything that happens in our communities, restrictions and all that stuff, mental health, social being stuff, it's also broken our own way of working kinships our natural way of working, respecting Elders*." (Aboriginal Community Leader, Ceduna)

Gaps in workforce capacity to meet AOD treatment needs: peer delivery, local service delivery: Gaps in workforce capacity to meet AOD treatment needs centred around challenges in attracting and retaining staff to work in a regional community, and the lack of Aboriginal staff employed in AOD services.

Additional service providers, services, and cooperatives filling gaps: Additional service providers filling gaps are mentioned under the heading 'Other types of AOD support used in AOD treatment' and included services providing transport assistance, human services, and culturally appropriate community engagement activities. No additional service providers were identified in interviews with local stakeholders.

Other types of support filling gaps (e.g. role of family) and how they can be strengthened: The family system was identified as a crucial support to those struggling with AOD use, particularly for Aboriginal peoples. However, local stakeholders' responses indicated the need for better integrating the family unit in the treatment of those struggling with AOD use. For instance, it was mentioned that if families visit Ceduna together, where a member of that family is engaging in AOD use, then they are unable to stay together at the 'town camp' because it is 'dry', with no alcohol or intoxicated people allowed entry into the facility. Likewise, families then may have to return to their communities without those who have been 'drinking' because they have missed or not been allowed on the bus. Hence, highlighting the importance of considering the whole family, particularly in the context of Aboriginal families.

> *"In terms of the relationships, family relationships…we recognize that's a very strong thing with the Aboriginal community, their family relationships, what effect has that had on them and what services have been put in place as a result of that to help out?"* (Mainstream Health Representative, Ceduna)

How to fill gaps: Several methods to fill gaps were identified by local stakeholders.

- ***Community consultation:*** In order to improve the cultural appropriateness of services, local stakeholders emphasized the importance of community consultation.

> *"We have to talk to the mob, people that are accessing these services about what sort of service they want and also talk to the remote communities about what it is that this mob want for their people as well…the needs of us urban blackfullas compared to remote blackfullas is going to be different, so we need to be able to cater for all of that…"* (Aboriginal Community Leader, Ceduna)

- ***Community-led decision making:*** Going a step further than community consultation, some stakeholders identified the importance of community-led decision making as a way to address gaps in the provision of AOD services. One Community Leader highlighted the importance of empowering communities to make their own decisions to address AOD issues within their respective communities.

  > *"There needs to be a flexibility and a sense of innovation with the way that the current funding services do operate"* (Aboriginal Community Leader, Ceduna)

- ***Connecting:*** One local stakeholder also mentioned the importance of encouraging and teaching people how to start having conversations with their friends and families, if they notice they might be engaging in excessive AOD use.

- ***'Wet Area':*** The idea of a 'wet area' was also proposed by local stakeholders, in responses to the 'dry zones' (alcohol free areas) in place in Ceduna. The idea behind this kind of area is that it would provide a safe, controlled and monitored area for local people to consume alcohol.

- ***Regular transport:*** Local stakeholders also expressed that regular bus services which could take people to and from surrounding communities, to avoid them sleeping rough in Ceduna and engaging in excessive AOD use, would be beneficial.

Potential for scaling-up current provision of services: Some local stakeholders conveyed that scaling-up and building the capability of current services, such as the Sobering Up Unit, would help such initiatives go one step beyond supporting people struggling with AOD use, and specifically provide services to address issues with AOD use.

With regard to scaling-up of current services, local stakeholders expressed that they felt the community would be able to facilitate this growth.

> *"I think we're lucky enough that we have a few of the big players like DASSA and ADAC, involved in our community. We have an understanding of drug and alcohol treatment services. So, I think that as long as those key services are engaged in scaling this up, ultimately the community can adapt and grow with it."* (Aboriginal Community Leader, Ceduna)

However, it was also acknowledged that scaling-up services would require careful consideration and that this would be a long-term process.

> *"We're trying to minimize the harm of this sort of behaviour and drinking, but ultimately, what we really need is that hard work done, the work where people sit down and actually make change and try to detract people from being addicted…that's a long process. It takes a lot of good people and local people, it takes a lot of experts, industry experts…people to support that as well…"* (Aboriginal Community Leader, Ceduna)

Workforce capacity, continuity of service delivery, and sustainability, peer delivery, importance of community knowledge: Despite current struggles with workforce capacity in Ceduna, local stakeholders believed that it would be possible to increase staffing levels in services. The importance of local people being employed was again highlighted as crucial to the success of AOD treatment, as local community members understand the issues with AOD in the community.

Guidance for the development of a grants programme

Lessons from past AOD approaches (what to and what not to replicate): One Community Leader provided the example of the Community Development Employment Projects program. This was a scheme designed to support Aboriginal and Torres Strait Islander communities in rural and remote Australia to provide employment, skill

development, and various essential and desirable municipal services for their residents. The Ceduna Community Leader voiced that this program was successful at engaging people struggling with AOD use, by providing them with employment, purpose, and skills, but that it was not continuing in the same capacity. This example underscores the importance of continuity of grant funding and availability of services along a pathway toward recovery.

> *"(AOD services) that worked (were) CDEP…then they got rid of the E and CDP…now I think they're going to restrict that further because now they have host sites, something like that I'm told. But those key programs they actually helped a lot of people that were experiencing drug and alcohol because it kept them engaged in something and then led them into appointments. And there was a link to upskilling or something like that, which is what they taught me because that's the end of the gap."* (Aboriginal Community Leader, Ceduna)

Successes with past and current grant funding: A success from past grant funding was simply the increase in funding overall in Ceduna, upon the initiation of the CDC. One local stakeholder expressed that this increase in funding helped to increase community ties and collaboration between services.

> *"With the debit card came a lot of support services, so we've been able to make sure that there's a number of supports in that process as well…a lot of funding coming into the region, we're able to have a bit more community. It's important that we all keep each other accountable in the process and make sure that we're getting 'bang for our buck'…"* (Aboriginal Community Leader, Ceduna)

Challenges with past and current grant funding: Challenges with past and current grant funding, specifically related to the difficulties of the grant application process within small communities, were raised.

> *"it concerns me that the small remote communities whether they, 1) got the personnel, who's able to write an appropriate grant application and be successful, because that in itself is a skill, and then 2) when you've got small numbers of people to actually doing the work, you're asking them to do the work, you're asking them to do the statistics, you're asking them to do the report writing and then that goes off to the government. They say yea or nay. And if it's nay, well guess what, community misses out."* (Mainstream Health Representative, Ceduna)

Further concerns were raised about the grant writing process, particularly around the strict requirements and criteria of grant applications. It was felt that these specifications mean that grant applications become far removed from the actual community issues.

> *"As someone that is applying for grant funding, it often becomes quite trivial, and doesn't allow you to actually address the community need from that qualitative and narrative point of view. It's very much what you do as project management approach, which when you're trying to implement programs that have a broader social impact, doesn't always fit neatly in a box"* (Aboriginal Community Leader, Ceduna)

In addition, further challenges to do with grant funding were related to the short-term nature of funding and the consequences that this has on securing staff. Local stakeholders expressed the importance of long-term grant funding which can provide job permanency, to attract works to the region.

Potential issues with implementing grant funding and how to avoid these issues: Potential issues identified with implementing grant funding included ensuring the appropriateness of services for the region. One Community Leader outlined the importance of identifying the needs within current services before implementing funding for new services.

> *"I think one of the issues would be if we've got new services coming into the region and opening up shop, a significant cost in terms of setup and relocation and getting footprint here and a lot of those resources that can otherwise be used in service provision…we need to identify pretty quickly what services do we need and what's already there and who it's best aligned with."* (Aboriginal Community Leader, Ceduna)

Ensuring grant funding and program success (potential grant making processes and structures): One of the key features to ensure grant funding and program success raised by local stakeholders was joint decision making between community members and grant funding bodies.

> *"I think that joint decision making is something that absolutely should be implemented across all funding bodies"* (Aboriginal Community Leader, Ceduna)

In line with joint decision making, one Community Leader felt that holding applicants accountable to the community, not just the funding body was crucial to ensuring grant funding and program success.

> *"What's the process to be accountable not just to the funding body, but to the community and not just your Board that might be community elected, but to the broader community.*" (Aboriginal Community Leader, Ceduna)

Conclusions and recommendations

Local stakeholders in Ceduna identify a clear need for more AOD treatment and support services. These services need to be holistic in their scope, incorporating family, recognizing and addressing social and economic determinants of AOD use, and treating underlying mental health issues. These services must also meet the diverse cultural needs of different Aboriginal groups. One avenue to ensuring the cultural appropriateness and safety of AOD services is through supporting and extending funding for Aboriginal led or Aboriginal Controlled Community organisations. Existing harm minimization approaches in the community can be built upon and strengthened to not only increase their reach, but also to encourage a connection to treatment services. Stakeholders' perspectives suggest that new funding coming into the community should be distributed via joint decision-making processes and structures that allow community AOD treatment and prevention leaders to collaborate, inform prioritisation and be accountable to one another. Stakeholders' perspectives also suggest that to reduce the likelihood of people in surrounding regional towns becoming 'stuck' in Ceduna and caught in a cycle of excessive AOD use, it is important for there to be regular transport in and out of Ceduna, as well as more short term accommodation that is not dependent on registering a specific figure on a breath test.

5. East Kimberley - Perspective of local stakeholders

Community AOD needs

Main social and health issues, and specific AOD issues: The main social and health issues identified by local stakeholders across East Kimberley included AOD use, domestic and family violence, and trauma. Stakeholders highlighted that drug use appears to be becoming a larger and more challenging problem than alcohol use in the community. Some respondents linked increasing AOD use with issues around domestic and family violence in the community. However, one local stakeholder expressed that it was not accurate to say that East Kimberley has an AOD problem, rather they expressed that this was a trauma problem.

> *"I don't think we have an alcohol problem, we have a trauma problem…We should be working with people, not with their problem."* (Mainstream Health Representative, East Kimberley)

Perceived drivers to uptake of AOD treatment: The main driver identified by local stakeholders to the uptake of AOD treatment was receiving a referral. Specifically, a referral from a medical service or a court-ordered referral.

Perceived barriers to uptake of AOD treatment: A key barrier to uptake of AOD treatment expressed by the local stakeholders consulted was a misunderstanding of the role of AOD services and treatment.

> *"The resistance is due to people don't understand what we do. We come from a person-centred harm minimisation framework, so if someone sits in front of me and says I don't want to change, then I'm not going to say 'you have to', I'm going to say, 'okay, are there related areas that you are worried about? Can we help that'?"* (Mainstream Health Representative, East Kimberley)

Another key barrier to AOD treatment identified by Mainstream Health Representatives in the East Kimberley area was a perceived limited desire to change among the people who are being presented to them for AOD treatment. Other barriers to treatment uptake were language and cultural barriers between AOD service staff and those needing treatment, exacerbated by limited Aboriginal staff members employed across AOD services.

Community attitudes to AOD services: Community attitudes towards AOD services, as reported by local stakeholders, indicated that there was a feeling of shame in the community around having to receive AOD treatment. In particular, services such as counselling were considered particularly taboo. Local stakeholders went on to add that, it was also felt that AOD services were short-staffed and that people in the community are not aware of what specific services are provided by AOD services. Other comments acknowledged that the community holds a strong understanding of the difficulties of AOD treatment and that families understand that people need the face-to-face help.

In addition, some local stakeholders shared that the general attitude within the community was that excessive alcohol consumption was the norm, and that people are more likely to be successfully treated for alcohol use, compared to drug use.

Mobility of people in need of AOD treatment: Local stakeholders cited three common places frequented for AOD treatment, including Wyndham, Broome and Darwin, by people from the East Kimberley region.

Some local stakeholders, including Mainstream Health Representatives, felt that there are a good number of AOD services covering the East Kimberley region and that effective outreach services occur regularly. On the other hand, other local stakeholders, including Aboriginal Community Leaders and AOD service providers, expressed that rather than outreach services, permanent services, specifically from a local Aboriginal Medical Service are needed in the East Kimberley region. It was stressed that this was particularly important as people must fund their own travel to

receive treatment in other towns. It was also acknowledged that people can be drawn to receiving treatment in other places, or in communities which are not their own, to be in a different environment and for privacy.

Features needed to make an AOD service culturally safe and appropriate for Aboriginal and Torres Strait Islander peoples: The biggest feature highlighted across all the interviews in East Kimberley to make an AOD service culturally safe and appropriate was by employing Aboriginal staff. Specifically, the importance of employing Aboriginal staff in the delivery of AOD services was emphasized. It was also stated that in their practice, staff must be mindful that they are working with people from other cultures. In addition, one local stakeholder mentioned that reframing and rethinking services in a way that is culturally safe and appropriate may also help to reduce the stigma around accessing AOD treatment.

> *"I prefer calling it yarning, rather than counselling, we're teaching them and educating them, the thought of counselling it's very intense."* (Mainstream Health Representative, East Kimberley)

Current provision of AOD treatment services

Existing AOD services and reach - both within and outside the local area: Some of the existing AOD services that were mentioned by local stakeholders included the A Better Life (ABLe) program, which provides support and advocacy to clients that are on the CDC and is delivered by Ord Valley Aboriginal Health Service (OVAHS). In addition, respondents identified The Strong Men, Strong Families program, delivered by Kununurra Waringarri Aboriginal Corporation ; the Seven Mile Rehabilitation Centre in Wyndham; the Wyndham Youth Aboriginal Corporation; Anglicare; the Ngnowar Aerwah Aboriginal Corporation, which also has a residential rehabilitation centre; Boab Health in Broome; and Regional Community Alcohol and Drug Services.

Other types of support used in AOD treatment: Other types of support for people identified by local stakeholders included:

- ***Community and family:*** Local stakeholders identified that Aboriginal people in the community played a central role in supporting their family members struggling with AOD use.
- ***Joongari House:*** Run by Wyndham Family Support Inc., Joongari House is a resource and information support service located in Wyndham that is open to all members of the community, and helps to connect people with services and provides a variety of social support such as, financial counselling.
- ***Kununurra Empowering Youth Initiative:*** This initiative focuses on children and young people in Kununurra, to ultimately reduce the significant youth incarceration rates during the school holidays, and to increase community and child safety during this period.

Success and challenges with current AOD approaches: Several challenges with current AOD approaches in East Kimberley were highlighted, including the prevalence of AOD in the community, making it difficult to avoid. In addition, respondents cited cultural and language barriers between AOD Service staff and those needing treatment, specifically for Aboriginal people.

Another challenge related specifically to the East Kimberley area was the utilisation of Fly In – Fly Out (FiFo) staff by some health care providers, and the transient and short-term nature of AOD service staff, which makes it especially difficult for long-term relationships to be built between staff and patients.

An additional challenge with current AOD approaches in East Kimberley was the lack of 24-hour services and support.

> *“They've set up a new stream called 'no wrong door' but when it comes to weekends there's no 'right door' either, because no one is open. That needs to be addressed."* (Aboriginal Community Leader, East Kimberley)

Many local stakeholders expressed that they have not observed successes with reducing AOD use in the community. Some expressed concerns with current approaches not being able to sufficiently cater to the needs of the community, due to limited staffing, limited service hours, and cultural and language barriers for Aboriginal peoples in particular. However, some local stakeholders acknowledged that AOD services are becoming more culturally safe and appropriate for Aboriginal people, as these services are employing more Aboriginal staff members and services are increasingly being offered by ACCOs, and that these will eventuate into improvements in the delivery of AOD treatments. One local stakeholder mentioned that some services are holding men’s and women’s yarning circles, which are important and culturally appropriate ways to engage Aboriginal community members in AOD treatment.

Current workforce capacity - peer delivery, local service delivery: Perceptions around workforce capacity among local stakeholders were mixed. Some felt that the community was sufficiently staffed and well-placed to staff and support current AOD services. However, other local stakeholders felt that many services are short-staffed, resulting in patients being turned away and asked to come back at another time.

Cultural safety and appropriateness for Aboriginal and Torres Strait Islander peoples: The perceptions around the cultural safety and appropriateness of current AOD approaches was that it was an area which needs improvement, but that small changes are being made as services are beginning to employ more Aboriginal staff. One local stakeholder emphasised the importance of a community centre in Wyndham, as it was felt that there was no other place in town which belonged to the people.

Gaps and how might these be filled

Gaps in the provision of treatment services: A significant gap in the current provision of treatment services in the East Kimberley region was the lack of 24-hour services for AOD support. Many local stakeholders mentioned that after-hours services, such as a local helpline, were missing and necessary for the community. Although we acknowledge the existence of a national AOD hotline and the Alcohol and Other Drug Support Service in WA, it is important to consider whether this provides the outcomes required, and whether support is delivered in a culturally appropriate manner.

Gaps were also highlighted in the delivery of services, specifically to do with staffing. In the East Kimberley region, the utilisation of FiFo workers in health care roles, instead of local people, and the short-term nature of AOD service staff, makes it difficult for long-term relationships and trust to be built between staff and patients.

> *“We need local people trained up to be in these roles because, one, they know the people, the people trust them, and a relationship can be formed and maintained, whereas, as it is now with most of our services it's Fly In – Fly Out every 3 years."* (Aboriginal Community Leader, East Kimberley)

Another gap was the length of stay in rehabilitation. Local stakeholders felt that the average stay in rehabilitation, around 3-months, was too short and not enough time for people to successfully recover from AOD use.

The financial cost of entering and travelling to residential rehabilitation, was another significant gap mentioned.

> *"A lot of the gaps fall back to financial resources. People have wanted to refer themselves, but they have to pay to travel to Wyndham or Broome for their own treatment and stay there but they can't afford it."* (Aboriginal Community Leader, East Kimberley)

Additionally, many stakeholders expressed the lack of prevention specific programs as a major gap.

> *"Prevention program has to be recognised and put it in place... Having prevention maybe we wouldn't need 'postvention' most of the time."* (Aboriginal Community Leader, East Kimberley)

The lack of follow-up support after people are discharged from AOD treatment was also identified by stakeholders. This was also extended to family support, with many stakeholders highlighting the need for families to be supported when a family member is undergoing and discharged from treatment.

Gaps in cultural appropriateness of services for Aboriginal and Torres Strait Islander peoples: A key gap in the cultural appropriateness of services was the lack of Aboriginal staff employed in AOD specific services. Local stakeholders also voiced that many Aboriginal people in the local community may not have the necessary skills and qualifications, and that training services must happen locally.

Gaps in workforce capacity to meet AOD treatment needs - peer delivery, local service delivery: Gaps in workforce capacity to meet AOD treatment needs largely centred around two key areas. Firstly, across all local stakeholders it was felt that not enough Aboriginal people are employed in AOD support roles and some local stakeholders felt that, in general, AOD services were not sufficiently staffed. The second major gap in workforce capacity in the East Kimberley region was the utilisation of FIFO workers in health care roles and the short-term nature of AOD service staff. This was identified as a contributor to treatment failure, as it makes it difficult for long-term relationships and trust to be built between staff and patients.

Additional (organizational based support) service providers, services, and cooperatives filling gaps: Regarding the lack of 24-hour support and limited support for families, the Kununurra Empowering Youth initiative, was raised as an initiative seen to be filling some of these gaps. This initiative focuses on children and young people in Kununurra, to ultimately reduce the significant youth incarceration rates during the school holidays, and to increase community and child safety during this period. Local stakeholders considered this a successful project as it was felt that several local organisations worked together to support the delivery. However, there have been some challenges in the Christmas period, as certain organisations have to pick up more of the workload because the majority of workers go on leave.

Other types of support mentioned by local stakeholders included Aboriginal organisations, such as Joongari House located in Wyndham, which was identified as helping to connect different services.

Other types of support (e.g. role of family) filling gaps and how they can be strengthened: Local stakeholders identified that Aboriginal people in the community played a central role to help to fill service gaps, especially around the lack of 24-hour support. This is because Aboriginal communities work together to support their family and people, especially outside of typical service working hours.

How to fill gaps: Several methods to fill gaps were identified by local stakeholders:

- **Potential for scaling-up current provisions of services:** In regard to the lack of 24-hour support, one Community Leader mentioned that he had suggested that local services share the workload over the weekends.

> *"We've got 6 recognised medical services in Kununarra, so why can't - between the 6 of them - they roster one social worker and one psychologist, to be rostered on one weekend in every 6, to be on call on a weekend - between Friday afternoon through to 8 Monday morning, and their numbers are given to the police, so that the police are the only ones who can ring them, when there's something happening, and then the following week another 2 organisations give 1 staff each to work that one weekend, so they're only working in every 6 - so that's not too hard."* (Aboriginal Community Leader, East Kimberley)

Many stakeholders felt that instead of scaling-up current services, better collaboration was needed among the current AOD services. Improvements in interagency communications were regarded as a central way to strengthen AOD services in the community. In line with this sentiment, one local stakeholder mentioned that Government bodies have tried to scale up services but that it became a confusing process, as it was felt that different organizations wanted to be leading this change, regardless of whether they were best placed for that role. As a result, it was felt that scaling-up of services needs to be done carefully and in consultation with local community stakeholders perhaps using a shared governance model.

- **Workforce capacity, continuity of service delivery, and sustainability - peer delivery, importance of community knowledge:** A key gap in workforce capacity was the lack of Aboriginal staff employed in AOD specific services. Some local stakeholders voiced that not enough Aboriginal people in the local community may have the necessary skills and qualifications, and so training services would be required locally to build local workforce capacity. In particular, one local stakeholder acknowledged that Kimberley Aboriginal Medical Services (KAMS) was providing training for Aboriginal people, but that people often have to travel to big cities for training, which would mean significant time away from home, accommodation and travel costs.

> *"A lot of our organisations cannot afford to do that. It would be good to have training come directly to remote communities"* (Aboriginal Community Leader, East Kimberley)

Further, regardless of qualifications and training, local stakeholders stressed the importance of employing local Aboriginal people in a support capacity, to ensure continuity and consistency with AOD case management. This would mean that even if those employed in medical service positions are mostly FiFo workers, there would at least be one local member of an individual's treatment team to serve as a point of consistency and trust for them.

> *"We need local people trained up to be in these roles because…, they know the people, the people trust them, and a relationship can be formed and maintained, whereas, as it is now with most of our services it's Fly In – Fly Out every three years."* (Aboriginal Community Leader, East Kimberley)

The employment of local Aboriginal people in AOD support roles was also considered a central way to improve the cultural appropriateness and safety of AOD services.

Guidance for the development of a grants programme

Lessons from past AOD approaches (what to and what not to replicate): Learnings from past AOD grant funding approaches emphasized the importance of transparency around who is receiving funding. For instance, one Community Leader provided an example related to the setup of a local AOD program. The Community Leader initially believed that $800,000 had been allocated to an Aboriginal health service for the delivery of this program but later heard that $350,000 of that funding went to another healthcare service.

Concerns around misuse of funding in the community were also expressed.

> *"People who get funding misuse it. They don't use it for the benefit of this town."* (Mainstream Health Rep, East Kimberley)

This suggests the importance of transparency in East Kimberley about how grant funding is distributed and how services utilise their grant funding.

Successes and challenges with past and current grant funding: Some successes that were highlighted with past and current grant funding were related to the ABLe program. Specifically, local stakeholders voiced that this funding allowed the program to take people out on Country, which they felt benefited people's treatment, by providing culturally appropriate care.

A challenge that was outlined with past grant funding was related to the restrictions around use of funding and duplication of programs. For example, one local stakeholder explained that funding would come in for a specific purpose but could not be re-directed to other programs, even if they were addressing the same issues in the community. This local stakeholder cited an example of when the community received funding for a Suicide Prevention program, although another Aboriginal organisation had already designed a Suicide Prevention program specific for communities in East Kimberley. However, they were not currently funded to implement the program and were unable to redirect the new funding to that program.

> *"When we heard that there was the Suicide Prevention funding coming through, and I was contacted by the team who said can we stop this from coming through and put it into the plan we already have? Like, they'd already done all that work and we tried and tried, we called, we emailed, we couldn't even get up the ladder. No one would listen to us. Here is a community that has got a Suicide Prevention Plan, they've worked together, it's from the Aboriginal orgs and we hear that there is money around and so can the plan be put in action?"* (Mainstream Health Representative, East Kimberley)

Potential issues with implementing grant funding and how to avoid these issues: Potential issues with the implementation of grant funding that were identified by local stakeholders related to community politics, concerns around the continuity of funding, and transparency around who is receiving funding. Thus, local stakeholders believed that program funding for successful programs should be continuous, transparent, and should utilise models from other regions that had evidence of their efficacy in the implementation of grant funding.

Ensuring grant funding and program success (potential grant making processes and structures): In order to ensure grant funding program success, local stakeholders highlighted the importance of the continuity of grant funding. Specifically, that programs should not stop and start as a result of funding, especially if they are successful programs.

A bottom-up approach was also mentioned as another way to ensure grant funding and program success. Local stakeholders expressed that the community needed to be consulted to ensure grant funding success and to ensure that programs are utilising findings in an appropriate and useful way.

> *"Community needs to have the ultimate say on the funding. How many times have we had funding thrown at us when we haven't even asked for it?"* (Mainstream Health Representative, East Kimberley)

Several local stakeholders also voiced that grant funding should focus on scaling-up services that currently exist, increasing methods that strengthen their work, and increasing their footprint throughout the region, rather than building new services. However, not all stakeholders agreed with this sentiment and believed that new services were required.

Conclusions and recommendations

Local stakeholders in East Kimberley identified growing need for AOD treatment services, particularly drug treatment services. They acknowledged the contribution of existing services and treatment pathways, but suggested that underlying challenges facing people struggling with AOD use are preventing them from successfully taking up those treatments. Stakeholders also identified limitations of existing AOD treatment services, including the limited accessibility and non-local nature of those services. In suggesting options for the future, stakeholders alluded to the importance of future funding going toward AOD services that have local practitioners who are grounded in the community and are culturally knowledgeable, can provide services on a 24-hour basis, such as a culturally appropriate telephone service, and are able to treat people for periods greater than three months. In addition, stakeholders identified a number of AOD support services which could be bolstered by additional funding. These services included preventative approaches and services that take a more holistic family-based and culturally-based

approach to treatment, as well as existing ACCO providing these types of services. These local consultations also suggested that future funding should be consistent and foster collaboration across AOD treatment and other support services, utilisation of best-practice methodologies for treating people, transparency in terms of who receives funding and how funding is being spent.

6. Goldfields - Perspective of local stakeholders

Community AOD needs

Main social and health issues, and specific AOD issues: Local stakeholders identified several social and health issues in the Goldfields region. Specifically noting that the region faced significant issues around poverty, homelessness, AOD use and mental health issues.

Additionally, one local stakeholder highlighted that there is a significant multicultural migrant community in Kalgoorlie, who face challenges with accessing health care and health information. In addition, Aboriginal communities face significant racism and discrimination, particularly from homeowners and rental agents, when attempting to secure housing. This local stakeholder also mentioned that Kalgoorlie was facing issues with testing and treatment of Hepatitis C, a virus linked to intravenous drug use that is often transmitted through users sharing needles.

Perceived drivers to uptake of AOD treatment: The key driver identified by local stakeholders in the uptake of AOD treatment was receiving a referral. Specifically, a referral from a medical service or a court-ordered referral.

Perceived barriers to uptake of AOD treatment: Several barriers to the uptake of AOD treatment were identified by local stakeholders, including:

- ***Stigma****:* local stakeholders highlighted the stigma associated with accessing AOD treatment as a significant barrier to help-seeking behaviours.
- ***Awareness****:* limited knowledge of local services which provide AOD specific services was identified as a key barrier to treatment uptake.
- ***Cost***: a significant barrier to AOD treatment uptake was the financial cost of attending rehabilitation services, in addition to, the cost of time away from work.
- ***Perceptions of individual barriers***: mainstream health representatives and AOD service providers expressed challenges around navigating AOD treatment with individuals who they perceive are facing other challenging life circumstances that undermine their desire or readiness to change. The local stakeholders explained that these life circumstances related to people using AOD to cope with trauma, mental health issues and other challenging circumstances, which providers expressed they have limited scope to address.

Community attitudes to AOD services: Community attitudes to AOD services were mixed. In general, many local stakeholders expressed a positive view on the current services in the Goldfields region, especially when speaking about local organisations, such as Bega Garnbirringu Health Service (an Aboriginal Community-Controlled Health Organisation) and Hope Community Services. However, there was also a general sentiment that AOD services weren't sufficient or well-supported to address the core drivers of AOD use, specifically, poverty, homelessness, and the general prevalence of AOD use.

> *"I think communities is keen to support it but again, like the social problems here, particularly poverty, homelessness and racism make it difficult for people to have the time and the energy and the sort of personal resources to help them."* (Mainstream Health Provider, Goldfields)

Mobility of people in need of AOD treatment: Local stakeholders explained that given the high rates of homelessness, people in the Goldfields region tend to live nomadic lifestyles, travelling between towns throughout the region.

Further, as the Goldfields region has a specific AOD rehabilitation service in Kalgoorlie, the Goldfields Rehabilitation Services Inc, those in need of AOD treatment do not typically travel outside the region for treatment. Other towns within the Goldfields region where people may access treatment included Leonora, and Esperance, which hosts a rehabilitation service called Adult & Teen Challenge Western Australia. Local stakeholders mentioned that this a successful program but was very expensive.

However, one local stakeholder, a local AOD service provider, explained that their service does provide referrals outside the region, specifically to a rehabilitation service in Geraldton, named the Hope Springs Community Farm. Another local stakeholder also mentioned that referrals are provided to the Next Steps Program in Perth, which provides a range of treatment services for people experiencing problems associated with AOD use. One mainstream health provider also added that people are sometimes referred to Albany for specific psychiatric treatment.

Features needed to make an AOD service culturally safe and appropriate for Aboriginal and Torres Strait Islander peoples: Local stakeholders outlined features central to the cultural safety and appropriateness of AOD services including:

- Employment of Aboriginal staff
- Cultural Awareness Training delivered to all non-Aboriginal staff
- Gender specific services, for example, female clients accessing a female counsellor
- For Aboriginal peoples in treatment – spending time on Country
- Acknowledging that the extended family should be allowed to visit family members undergoing rehabilitation or detoxification particularly for Aboriginal families

Current provision of AOD treatment services

Existing AOD services and reach - both within and outside the local area: The existing AOD services identified by local stakeholders in the Goldfields region included:

- **Hope Community Services:** provides a range of support services across the region, including the Goldfields Community Alcohol and Drug Service (GCADS).
- **Goldfields Rehabilitation Services Inc.:** has a residential rehabilitation and transitional program and detoxification program
- **Bega Garnbirringu Health Service:** an Aboriginal Community Controlled Health Organisation (ACCHO) located in Kalgoorlie-Boulder which provides a range of healthcare services to Aboriginal communities across the Goldfields region and delivers the Sobering Up Shelter.
- **Transport assistance:** the MEEDAC bus, recently re-named Connectors, is a harm reduction service, that provides transport and care for at-risk community members, especially for intoxicated adults. They help to transport people to their homes, medical appointments and other locations.
- **Sobering Up Shelter:** the Sobering Up Shelter provides a safe place for those affected by AOD use to sober up. Those who are repeat clients will receive assistance with their AOD issues through a referral service for counselling or other support. This shelter is run by Bega Garnbirringu Health Service.

Other types of support used in AOD treatment: Other types of support for people identified by local stakeholders included:

- **Human services:** Local stakeholders mentioned other types of care services which they commonly referred to as 'The Care Bears', this included Anglicare, Communicare, CentreCare, Salvation Army, Red

Cross and Life Without Barriers. While these organisations may not treat AOD issues specifically, local stakeholders noted that they support people in other ways such as by providing temporary housing and counselling.

- **Mental Health Services:** Headspace Youth Mental Health was specifically noted as providing integrated team care for Aboriginal people with chronic mental health conditions. CentreCare was also cited as key mental health services in the Goldfields region.
- **Step Up/Step Down service:** This service provides short-term residential mental health support for people in the Goldfields region. Specifically, 'Step Up' support is provided for people who are either becoming unwell and are at risk of being admitted to hospital or 'Step Down' support is provided for people who are leaving hospital but need additional support to transition back into daily life.

Successes with current AOD approaches:

- ***'No Wrong Door' approach:*** The 'No Wrong Door' approach is an initiative where no client is turned away from treatment; and when a person presents at a facility that is not equipped to provide a particular type of service, such as AOD treatment, they are referred to an appropriate service. This approach is implemented in Goldfields and was identified as a success, as it has increased the number of people being referred into appropriate AOD treatment.

  "I think that's a testament to our capacity to what we call like a No Wrong Door approach, which is just trying to make sure that people refer to our service that we don't like, say, "No, you're not eligible." But even if someone were to come to the service, and there was a particular concern that they had there was made them whatever is not ideal for our service, we would try much as well to refer them to a service that was – what we've seen is that we've had more, more referrals, and we've been able to work and be more flexible and have different impacts." (AOD Service Provider, Goldfields)

- ***Ongoing outreach:*** One local stakeholder, an AOD service provider, highlighted the success of outreach contact even after people finish treatment, to check-in and help drive individuals' transitions back into their community.

  "We still offer them outreach. We've had men that will still want to be connected and so whether that's a weekly check in, just catching up and saying, 'Oh, hey, how are you, how are you going?' And even now we have men who still are connected to the Outreach Program." (AOD Service Provider, Goldfields)

- ***Individual successes:*** When speaking about the successes of AOD approaches, local stakeholders cited examples of individuals who have completed rehabilitation and have been able to secure employment and stability post-treatment.

  "One of the patients that was working here as recently as August, finished here, after a year, got an employment here and work for the next two years and was able to reconnect with their family, got their child back and going really well. So there has been some successes that we can actually identify and say, yeah, they've gone on in they're still going on quite strong." (AOD Service Provider, Goldfields)

- ***Aboriginal run organisations:*** A key success outlined by local stakeholders were having Aboriginal run AOD services, specifically citing Bega.

"*In this town is an organisation like Bega where you've got an Aboriginal organisation, a non-profit one that's out there and hands-on. They're all Aboriginal people, we're all Aboriginal and we're dealing with the issues as they happen and they find that very rewarding".* (AOD Service Provider)

Challenges with current AOD approaches: Several challenges with current AOD approaches were outlined by local stakeholders

- ***Retention***: local stakeholders explained that an overarching challenge associated with current AOD approaches is to do with retaining people in AOD treatment. Several local stakeholders had observed that people do not always attend appointments, and that this was related to a lack of internal motivation to discontinue AOD use.

  "Within this service, we have a lot of challenges around, maybe people attending their appointments, because people might want to attend one day, and the next day, they might not want to attend. So, it's about retaining people and just because people use alcohol and other drugs, doesn't mean that they want to have treatment for their alcohol and drug use." (AOD Service Provider, Goldfields)

- ***Access***: one Aboriginal Community Leader explained that it was challenging for people to access AOD support services, as wait times are long.

- ***Cultural appropriateness***: a significant challenge mentioned by some local stakeholders was the cultural appropriateness of current AOD approaches for Aboriginal peoples. In particular, local stakeholders referred to rehabilitation as not being culturally appropriate and safe. One Aboriginal Community Leader explained that to Aboriginal peoples AOD rehabilitation was similar to being imprisoned.

  "It's just like a prison. People go to prison, and they dry out and they do their medicals and all that. As soon as they walk through that gate, they're back to what they're doing. So, the rehabilitation is exactly the same for Aboriginal people." (Aboriginal Community Leader, Goldfields)

- ***External Factors:*** local stakeholders outlined a significant driver of AOD use was due to poverty and homelessness, and that these issues are not addressed during treatment, meaning people often return to engaging in AOD use once they leave rehabilitation. In addition, the general prevalence and exposure to AOD use in the community was considered another challenge that is unaddressed in current AOD approaches.

  "*It's so much affected by the people around you and being able to get away from them and also the family pressures and the pressures of poverty and homelessness compounded or so they're all big factors."* (Mainstream Health Provider, Goldfields)

  "It's very hard for them to – once they get that circle, it's hard to get out of that circle of drinking and smoking and it's very hard." (Aboriginal Community Leader, Goldfields)

- ***Vastness of the region:*** the vastness of the Goldfields region was considered another challenge to successful AOD treatment. It was felt that it was difficult to effectively service the region, which spans approximately 800,000km^2.

  "The sheer expanse of the whole region has to be reached, and how do you know to have enough? How do you get resources out to those reach and getting them there, and then maintaining resources there? (AOD Service Provider, Goldfields)

- **Current workforce capacity - peer delivery, local service delivery:** Comments on current workforce capacity related to the vastness of the Goldfields region. Given the region spans approximately 800,000km^2, it makes it very challenging for small local organisations to cater for the entire region.

> *"The programs, when they're funded, they're funded to cater for the whole of Goldfields. However, working the Goldfields it's really hard for the outreach aspect of getting the services to where it's required. It does put a strain on staffing whereby you've got for instance, a program may have to cover like Kalgoorlie, Kambalda, Coolgardie, Leonora, Laverton, Wiluna, Norseman, Esperance, Ravensthorpe, I mean, and then we maybe have three or four staff and maybe one or two vehicles to cover that whole area."* (Mainstream Health Provider, Goldfields)

> *"In an ideal world, it'd be great to have more funding for more staff, there's a few different models and approaches what we'd like to try out in the communities but we've also got to be mindful the areas that we cover, some of them are a nine-hour drive, without passing anything. So that's kind of like two days just to literally kind of get to the location, set up base, and before you've even done any work. So there's a lot of stuff."* (AOD Service Provider, Goldfields)

Further comments on workforce capacity related to the transient nature of the workforce in the region, where externally-hired workers tend to stay for a short-term period. Some local stakeholders explained that this is why they have seen success in building a local peer workforce.

> *"So if you're looking to grow and develop a workforce - a local workforce, - you can include and integrate people at different levels along that journey, whether you start looking at a peer workforce, or then you work through a case management model up to your counsellors or your psychologist, so your stepped approach, then you can bring people on the journey and train them up. In our experience, we've had a lot more success doing that than we have had with people coming in."* (AOD Service Provider, Goldfields)

Cultural safety and appropriateness for Aboriginal and Torres Strait Islander peoples: Local stakeholders' thoughts on the cultural safety and appropriateness of current AOD services were mixed and tended to be specific to different services.

For instance, one local stakeholder, an Aboriginal mainstream health provider expressed disappointment as they independently deliver their own cultural awareness training to their new staff members, but that new staff are not required to complete cultural safety and awareness training when joining the hospital.

It was also felt that cultural safety and appropriateness of services was impacted by the transient, short-term nature of the workforce. Local stakeholders expressed that with staff not being in the community very long are unable to fully understand the complexities of Aboriginal family and culture.

However, other stakeholders felt that the AOD services within the Goldfields region were providing a high standard of cultural safety and appropriateness in their treatment. This sentiment was also supported by some Aboriginal Community Leaders. In particular, the employment of Aboriginal staff throughout different organisations in the region was highlighted as a major success of local AOD services. Specifically, it was outlined that Aboriginal staff members are currently employed within AOD services throughout the region, including three Aboriginal staff members holding senior positions. Another related success was a local men's group run by an Aboriginal coordinator who takes Aboriginal men undergoing treatment out on bush instead of a classroom approach. Local stakeholders considered this an important example of how to incorporate culturally safe and appropriate practices into treatment.

Gaps and how might these be filled

Gaps in the provision of treatment services: Several gaps in the current provision of treatment services were identified by local stakeholders:

- ***Child-specific AOD services:*** One mainstream health provider explained that the rates of children engaging in AOD use are increasing, however, services are targeted for adults, aged 18 and over.
- ***Increased privacy:*** while the Goldfields Rehabilitation Service Inc (GRSI) was looked upon positively by many local stakeholders, some mentioned that many would benefit from a rehabilitation service that is distanced away from the main community areas, so that people can escape peer group stigma and peer pressure to engage in AOD use.
- ***Prevention:*** Local stakeholders expressed the lack of prevention programs in current treatment services.

  > *"It runs a good rehabilitation, but of course it's too late by the time they need rehabilitation. In terms of prevention there's not a huge amount that I can think of, and not – there's not a lot around."* (Mainstream Health Provider)

- ***Mental Health Services:*** local stakeholders expressed the need for further mental health-specific services with capability to work with individuals struggling with AOD use.
- ***Community Arts:*** one local stakeholder expressed that art can be an effective method incorporated into AOD treatment but is currently not in place in any of the local AOD services.
- ***Women's specific AOD groups:*** Several stakeholders mentioned the success of the men's AOD group run by Hope, but also expressed the need for a similar initiative, for women specifically.

Gaps in cultural appropriateness of services: Gaps in the cultural appropriateness of services centred around the need for more Aboriginal run services, specific to targeting AOD use. It was also considered important for services to acknowledge the role of the extended family in the treatment and care of Aboriginal peoples.

One Community Leader expressed that spending time on Country was essential to culturally safe and appropriate care for Aboriginal peoples, citing Hope's men's program as an example of this success and calling for more programs facilitated on Country.

Gaps in workforce capacity to meet AOD treatment needs - peer delivery, local service delivery: Gaps in workforce capacity were identified as a key concern for many local stakeholders. Especially, the need for more qualified staff, who could stay on for a longer-term basis.

> *"Funding is really good, but you don't have the staff to actually deliver or deliver the program, it still creates that gap in service as well."* (AOD Service Provider, Goldfields)

> *"Like I said before, it's really these gaps around staffing in the region here, like I believe, very transient. So again, you have a lot of staff come they go, it's almost a norm, basically. So that that becomes a problem, so I think sometimes, too, we – and that goes for us"* (AOD Service Provider, Goldfields)

Additional service providers, services, and cooperatives filling gaps: Additional service providers filling gaps are mentioned under the heading 'Other types of support used in AOD treatment' and included services providing transport assistance, human services, a safe space to 'sober up' and mental health services. No additional service providers were identified in interviews with local stakeholders.

Other types of support (e.g. role of family, Aboriginal organisations) filling gaps and how they can be strengthened: Other types of support that are helping to fill gaps in AOD services included:

- ***Family:*** family was considered a key form of support in an individual's AOD treatment journey. One local stakeholder mentioned that allowing families to stay together in rehabilitation may strengthen the supportive role of family in AOD treatment.

  "Also, perhaps, consider a similar program like that [Hope Springs Residential Rehabilitation], but allow the family to all go together into a live in residential long-term program where you learn skills as well as getting off drugs and alcohol." (Mainstream Health Provider, Goldfields)

  "I will say another aspect is really understand the whole concept of family. That when a particular Aboriginal person comes is not just, it is about them, but it's much more than that, you've got the Aunties and Uncles and cousins. It's a whole family concept" (AOD Service Provider, Goldfields)

- ***Aboriginal Cultural Centre***: was identified as another form of support, providing a place for community members to gather and engage in activities such as art. However, they are currently about to lose their building, due to a lack of funding.

  "Aboriginal Cultural Centre, but we're about to lose our building because we can't afford to keep it. We don't have any funding, people used to come to art group and women's group or men's group and each time they would come, they would give like a gold coin donation, but with the Indue card [CDC], here that's made things way worse. People don't have the cash so they can't contribute in that way." (Mainstream Health Provider, Goldfields)

How to fill gaps: Local stakeholders identified several methods to fill gaps.

- ***Youth Specific AOD health education***: several local stakeholders expressed the importance of education on AOD use for youth, as a prevention method.
- ***Early intervention***: identifying children in school who may be vulnerable to AOD use later on, and supporting them earlier on was also considered an important prevention method**.** Signs included; children who appear to be unhappy at school, are not demonstrating that they are learning or enjoying learning or are acting out in the classroom.
- ***Arts-based model:*** Another method to fill service gaps was the idea of an 'arts-based' model. This model was based on the idea that community arts and individual art projects have demonstrated significant improvements in mental health and AOD use in the community, in the past.

  "There was a program a long time ago, 30 years ago when I first came here that was run through Heathway…she was helping people get started painting as a way for them to think, address a lot of their emotional problems, get recognition for skill. That's an income as well and for a lot of people that was very effective in helping them through….and that can be much more effective than actual medical services." (Mainstream Health Provider, Goldfields)

- ***Supply restrictions:*** Local stakeholders expressed harsher restrictions on alcohol may help to reduce AOD use.

  "I'd like to see more restrictions on the sale of alcohol too. That makes it hard on how these people – my mob here, they carry on. Yeah, there's restrictions in place now but I reckon tougher ones." (Aboriginal Community Leader, Goldfields)

- ***ACCOs:*** Several stakeholders mentioned that more ACCOs targeting AOD use is essential to addressing gaps in the cultural safety and appropriateness of services.

> *"An Aboriginal-owned and operated and managed agency to deliver those programs. Bega does it, but I think, for alcohol and drug, they're going to specifically for that, that needs a new – an organisation which can focus entirely on them services."* (Aboriginal Community Leader, Goldfields)

Potential for scaling-up current provisions of services: In general, local stakeholders felt confident in the community itself to deliver AOD services and that more funding would increase the capacity, effectiveness and reach of services. However, a key barrier to the scaling-up of current services was related to limited staffing and challenges attracting staff to the region.

Additionally, many local stakeholders believed that smaller, more specific services were more effective at delivering individual treatment.

Workforce capacity, continuity of service delivery, and sustainability - peer delivery, importance of community knowledge: In order to solve the problem of transient and limited staff, several local stakeholders mentioned the benefits to engaging and training local people to work within AOD services.

> "*People come in and out, and they don't stay because they're not committed to the region, in most instances. So, being able to train local people is much better."* (AOD Service Provider, Goldfields)

An increase in telehealth services was also proposed as a potential method to fill the limited workforce capacity.

Guidance for the development of a grants programme

Lessons from past AOD approaches (what to and what not to replicate): One Mainstream Health Provider provided the example of the Community Development Projects (CDP) program, as a successful program which addressed some of the key drivers to AOD uptake, such as unemployment. The CDP program was a scheme designed to support Aboriginal and Torres Strait Islander communities in rural and remote Australia by providing employment, skill development, and various essential and desirable municipal services for their residents. The local stakeholder voiced that this program was successful at engaging people struggling with AOD use, by providing them with employment, but that it was not continuing in the same capacity. This local stakeholder also added that the Aboriginal and Torres Strait Islander Commission (ATSIC) also empowered local artists to earn income from their work through the CDP, but that the Institute no longer exists in the community. Taken together, these examples underscore the importance of continuity of grant funding and availability of services along a pathway toward recovery.

> *"With the loss of ATSIC, things became much more difficult and we don't have CDP available in Kalgoorlie, so CDP was great, particularly people in this group with drug and alcohol problems or poor personal resources, and they could be on the CDP, and be working as artists at the centre and then topping up from sales at markets and things and that's all gone."* (Mainstream Health Provider, Goldfields)

Other lessons learned from past AOD approaches that were viewed positively were local services working collaboratively, to ensure the most effective and supportive AOD treatment. However, it was acknowledged that since local AOD services have limited staffing and are servicing a vast region, it is challenging for services to find the time to work collaboratively. Thus, increasing staffing may help services to have the capacity to work collaboratively.

> *"People try to work collaboratively, but with a lack of resources, it's pretty hard to actually work collaboratively and people are busy."* (Mainstream Health Provider, Goldfields)

Successes with past and current grant funding: A recent and current grant funding success mentioned by a local AOD service provider was the Summer Response Strategy. The local stakeholder explained that this program was developed in response to the death of three young local women who were run over by cars, attributed to the lack of lighting in the area. Thus, the program aims to increase safety in the Goldfields region, by providing people travelling

throughout the region, who may otherwise end up sleeping rough, with access to transport home. The program relies heavily on local community members and collaboration with local services, with a new shop front open where the public are welcome to come in for a coffee, some food and have access to a phone. The local stakeholder also explained that there are different streams to the program. In addition to transport throughout the region, there was an 'event stream' where children were provided with travel to and from, activities throughout the summer, and a 'policing stream' which involved police patrol.

> *"So there was buses that would go back on a regular basis, so people would come they pop their name down, want to go back, the bus would there was a there's a bus stop across the road, a central spot. People would meet there in the morning, at an agreed time, have a barbecue… They went up on the bus back up back to country and back home and then there was also another stream which was an event stream. So, there was activities at the PCYC for the kids and barbecues in the parks and things like that for people to access, and then a mobile policing stream, so your policing response just for safer streets and whatnot. So, but that proved really successful."* (AOD Service Provider, Goldfields)

The local stakeholders explained that the program was funded by several agencies but that recent funding received by BHP as part of their COVID-19 funding, allowed them to fund an organisation to manage the shopfront. The Summer Response Strategy ran from November 2019 to February 2020 and was considered a success, with plans to run again in 2021 and an evaluation underway, by the University of Western Australia. The local stakeholder emphasized that the program especially underscores the community's ability to work together to ensure grant funding success.

> *"Our community has already demonstrated our capacity to work together to have a common purpose, and to be able to work in our own areas to be able to serve more people in a coordinated way."* (AOD Service Provider, Goldfields)

Furthermore, when discussing past grant funding successes, one mainstream health provider, mentioned the success of the maternal-infant health program, *Ngunytju Tjitji Pirni* (NTP). They explained that this program trained local Aboriginal women to specialise as maternal and infant health workers, who then conducted home visits to help women during and after their pregnancy. In addition to antenatal specific care, they also provided pregnant women support to stop engaging in AOD use. In particular, the local stakeholder highlighted that the success of the NTP program was due to the tailored individual support. Speaking about the program the health provider noted:

> *"[The NTP] was extraordinarily successful in all areas, and particularly in helping their women before during and after pregnancy and supporting them and helping them, having someone knowledgeable and caring, coming and visiting you, providing medical care, but also the support to get off drugs and alcohol…. but there's nothing has taken the place of that home visiting, individual support, which I think is what you really need."* (Mainstream Health Provider, Goldfields)

State and Federal funding for this program was discontinued in 2015, however, due to organisational challenges. This highlights the importance of continuity in grant funding and organizational capacity to successfully serve the community.

Challenges with past and current grant funding*:* Challenges to do with grant funding related to the short-term nature of certain grants and the related challenges of recruiting staff for short-term grants. In particular, it was expressed that:

> *"It is really hard particularly in Kalgoorlie to recruit people on short term grant funding, because people don't move to Kalgoorlie very willingly, and the pool of people who*

are already there. They might jump from one organisation to another, but it's very hard to recruit and short-term staff is even harder to recruit too, just because people don't want to make the move out there." (Mainstream Health Provider, Goldfields)

Potential issues with implementing grant funding and how to avoid these issues: While no potential issues with the implementation of grant funding were specifically mentioned, it was expressed that community consultation in grant funding implementation would ensure program success.

Ensuring grant funding and program success (potential grant making processes and structures): Co-operation and collaboration between organisations applying for grant funding was considered key to ensuring grant funding success.

Again, local stakeholders emphasized the importance of community driven programs and for programs to take a specific approach. Specifically, smaller local organisations can better cater to the community by building more personal relationships between staff, community, and patients.

> *"No one program is going to make the whole need anyway. So if you can do one group here and one group there, that's why you don't have to – I mean, they seem to want you to be able to be everything to everyone, and that's bound to fail, managed much would be much better if it was smaller. That allows for meaningful relationships between staff and community participants or clients for them, is probably the thing that's going to make the biggest difference. So you don't want a great big organisation and see that with what's happened with every medical service here. Started off really small and intimate and very effective, now, it's massive."* (Mainstream Health Provider, Goldfields)

Further, the importance of ACCOs directly receiving funding was also highlighted as key to grant funding success. Rather than funding for Aboriginal specific programs and services being channelled through mainstream organisations, funding given directly to ACCOs will ensure grant funding is used to run culturally appropriate and safe programs.

Conclusions and recommendations

Local stakeholders in the Goldfields region identified a clear need for more AOD treatment and support services, to cater for this vast and expansive region. Stakeholders identified that these services are most successful when delivered in a culturally appropriate, holistic way that meets the individual needs of patients. While some services are leading the way in culturally safe and appropriate care, there is a clear need to continue to improve the cultural appropriateness of AOD treatment services across the region, particularly through funding for Aboriginal led organisations, ACCHOs and engaging local community members in specific staff and support roles, specifically local Aboriginal community members. Future funding can support the growth and strengthening of existing treatment services, with a focus on identifying methods to increase staffing across the region. The importance of funding being delivered directly to ACCOs as opposed to mainstream organisations running Aboriginal specific services, was also identified as being essential to ensuring the cultural appropriateness of services. Stakeholders also identified that the community is well-placed to work together to ensure grant funding and program success, as depicted by the success of the Summer Response Strategy.

Future funding can also serve to establish services to address the increasing rates of children engaging in AOD use.

7. Bundaberg & Hervey Bay - Perspective of local stakeholders

Community AOD needs

Main social and health issues, and specific AOD issues: The main social and health issues identified by local stakeholders across Bundaberg & Hervey Bay included homelessness, unemployment, intergenerational trauma, poverty, AOD use, mental health problems and chronic disease. Many local stakeholders identified homelessness as a key social and health issue. Local stakeholders explained that homelessness was linked to a lack of affordable housing and long wait times for social housing, across the Bundaberg & Hervey Bay region. Local stakeholders also identified that racism towards Aboriginal people, from homeowners and rental agents was another key barrier in securing housing. Difficulties securing housing was also related to overcrowding within households.

Local stakeholders also highlighted that the complex interplay of these factors is central in the development of problematic AOD use. Specifically, difficulties finding employment and housing, coupled with intergenerational trauma were considered key drivers in the uptake of AOD use in the Bundaberg & Hervey Bay area.

> *"They are stuck here (Bundaberg) with no money to get out, that's why they use drugs or grog. You know, they have intergenerational trauma, personal trauma, it's no wonder our people misuse drugs and alcohol."* (AOD Service Provider, Bundaberg)

> *"A lot of our young people are affected because their parents were Stolen Generation, they didn't get any help to help them deal with being stolen. They (Stolen Generation) drink or have drugs to deal with their pain [and] they become parents and they struggle [to bring their kids up]. Young ones who don't work get the dole and, you know, they have [too much] time … they end up taking drugs and go downhill. Our people don't want to charge up [drink] and take drugs."* (Aboriginal Community Leader, Bundaberg)

Perceived drivers to uptake of AOD treatment: The main driver identified by local stakeholders in the uptake of AOD treatment was receiving a referral. Specifically, a referral from a medical service or a court-ordered referral.

Perceived barriers to uptake of AOD treatment: Several barriers to the uptake of AOD treatment were outlined. Specific to the Bundaberg area was that there is no local rehabilitation facility. Interviewees acknowledged that Queensland Health was currently building a local residential rehabilitation, but that this was not expected to open until 2022 or 2023. The lack of a local rehabilitation facility also meant that people needed to travel long distances for specific treatment, which was particularly difficult when an individual may not have access to transport and are in a state of vulnerability, where they are struggling with AOD use and other health issues.

> *"They've got to travel all the way down and give them – get the HADs referral. Then they've got to look to – some of them are not feeling - people don't want to do anything, do you know what I mean? They need to have a hand, you know, have support. So, for them to get on a train all the way down there by themselves – okay, we can get the patient transport thing like funding and that, but I know to link in with the business workers there that pick them up and that but that's very daunting and it's very – they're very vulnerable."* (AOD Service Provider, Bundaberg & Hervey Bay)

Barriers to the uptake of AOD treatment were also related to staffing. Firstly, the limited number of Aboriginal and Torres Strait Islander staff was considered a key barrier in Aboriginal peoples' receiving treatment for AOD use. This was thought to significantly impact the cultural safety and appropriateness of services, which was also identified as a key barrier in the uptake of AOD treatment for Aboriginal peoples, across the region. In addition, limited numbers of

male staff in the AOD sector were identified as a key barrier, as that is perceived as impacting the availability of men's specific treatment services.

Community attitudes to AOD services: Community attitudes towards AOD services were linked to perceptions and feelings of shame around needing treatment.

> *"People are very resistant, there's lots of shame - the people we actually get through the door feel very overwhelmed."* (ACCHO Representative, Bundaberg & Hervey Bay)

Further, local stakeholders expressed that the general community perception of AOD services were that they were not culturally appropriate for Aboriginal peoples, and that they were not well equipped to manage comorbidities of AOD use, such as mental health problems.

> *"There's nothing here for our mob. And then mental health just kicks them out, because mental health does not want to deal with our alcohol and drugs clients here."* (AOD Service Provider, Bundaberg & Hervey Bay)

Mobility of people in need of AOD treatment: People living in Bundaberg often travel to surrounding areas, such as Gayndah, Cherbourg, and Hervey Bay, especially as they may have family members or cultural ties to those surrounding areas. Local stakeholders also added that people often move in and out of the region, particularly Maryborough, to be close to family members in the Maryborough Correctional Centre.

Currently, there is no local rehabilitation facility in Bundaberg. As a result, people in need of AOD treatment must travel to surrounding areas for rehabilitation and specific care. Mostly, people would need to travel to Brisbane (about a 4.5 to 5 hour drive one-way). However, local stakeholders outlined that not many people do this, as it is contingent on people having access to a car.

> *"I guess, yeah, we do see people, 'Yeah, I've been living over at Cherbourg for a year, but I'm just back in town for a few months.' They'll come and access us here [Bundaberg]. Yeah. That's okay, we're a really flexible service, we're happy to do that."* (ACCHO Representative, Bundaberg & Hervey Bay)

Features needed to make an AOD service culturally safe and appropriate for Aboriginal and Torres Strait Islander peoples: Features that are needed to make an AOD service culturally safe and appropriate include employing Aboriginal staff and including male & female Elders in the delivery of AOD services. In addition, providing cultural awareness training to incoming non-Aboriginal staff that is specific to the needs and features of the community that they will be working in.

Current provision of AOD treatment services

Existing AOD services and reach - both within and outside the local area: In Bundaberg, existing AOD services cited by local stakeholders included:

- **Queensland Health AOD Services**, which also provides a needle and syringe program
    - The Needle & Syringe Program is a harm minimisation service which provides sterile injecting equipment, education & information on blood borne & viral infections, transmission & risk behaviours, safer drug use & health
- **Galangoor Duwalami Primary Healthcare Service**, an Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Service
- **Indigenous Wellbeing Centre**, an ACCO, which specifically runs a Men's and Women's AOD group
- **Bridges Health & Community Care**, which provides specialist AOD treatment

- **Breakthrough for Families program**, a program for family, friends and partners of people struggling with AOD use and offers tools and strategies on how to talk to loved ones about their AOD use, better respond to and manage challenging behaviours, and make self-care a priority. This program has a culturally safe adaptation for Aboriginal and Torres Strait Islander Families, Breakthrough Our Way, led by the Queensland Aboriginal and Islander Health Council (QAIHC).

In Hervey Bay, existing AOD services that were cited by local stakeholders included:

- **Queensland Health AOD services**
- **Bridges Health & Community Care**, which provides specialist AOD treatment

Other types of support used in AOD treatment: The role of family was raised as a key AOD support for Aboriginal families in particular:

> *"…big thing with our mob, we're very family orientated. We're very close, and one thing affects the whole family."* (AOD Service Provider -Bundaberg & Hervey Bay)

Further, local stakeholders mentioned that Bundaberg has a Central Queensland Indigenous Development (CQID) office, which also helps to support individuals struggling with AOD use, by providing referrals to other services.

> *"CQID, we have lots of Indigenous services, that probably on a daily basis deal with AOD, where they refer to wherever and whatever Indigenous service that they choose."* (Mainstream Health Provider, Bundaberg & Hervey Bay)

Success with current AOD approaches: The following success were identified by local stakeholders:

- ***Collaboration:*** some local stakeholders expressed that when AOD services work together, this makes for a successful AOD treatment approach. One local stakeholder outlined the collaborative work that they engage in as a successful AOD approach.

  > *"We do a bit of joint work with [another local organisation]. Yeah, so that kind of model works quite well, but I guess the thing with the whole working in collaboration with [that local organisation] is it's very dependent on personal relationships. If I was to leave tomorrow, and some of the key workers from [that organisation] were to leave, and we were replaced by people who didn't know each other, that relationship wouldn't continue. It's pretty unique in this region, that a lot of collaboration is based on relationships, and people knowing each other, people trusting."* (ACCHO Representative, Bundaberg & Hervey Bay)

- ***Harm Minimisation:*** several local stakeholders acknowledged the success of the needle & syringe program at Bundaberg Hospital. The program has been noted at being successful at reducing rates of HIV and Hepatitis C in the community.

  > *"Providing sterile equipment has prevented a large amount of HIV and Hep C in the community that's a success."* (Mainstream Health Provider, Bundaberg & Hervey Bay)

Challenges with current AOD approaches: Various challenges were outlined by local stakeholders, including:

- ***Consistency of staff:*** a key challenge was retaining staff for a long-term period. This was considered a significant challenge given high staff burn out rates and the cost of housing in the region. One local stakeholder also explained that having consistent, long-term staff was conducive to treatment success, as it allowed solid relationships to be built between patients and staff:

  > *"From our experience here, that, it is a long-term process. A lot of our clients come back and forth to us regularly, so having that consistency of staff consistencies of programme over a long period of*

time, we know these guys make massive changes, if we're consistent, and they're regular." (Mainstream Health Provider, Bundaberg & Hervey Bay)

- ***Limited Aboriginal staff:*** another challenge outlined with current AOD approaches included the lack of Aboriginal staff employed in AOD support positions. This was considered a key barrier preventing the engagement of local Aboriginal people into local AOD treatment.
- ***Limited collaboration:*** while some local stakeholders identified this as a success when it does take place, other local stakeholders raised concerns that local AOD services work too independently of each other. Interagency collaboration, particularly when it comes to referrals, was seen as crucial to treatment success.
- ***Increasing pressure on services:*** local stakeholders expressed a more recent challenge to be related to an increasing pressure and high demand for AOD services. These have been brought on by a variety of factors, including the COVID-19 pandemic, NDIS funding inducing a shift in providers, the increase in private practice and housing costs.

  "I think the further away you get from Brisbane, the less you're funded, and that was before we ended up with a huge influx of people moving here. I think, yeah, the COVID stuff has really created a whole extra dimension of complexity and pressure on services. The other big thing that's happened in this region is around NDIS. When NDIS was rolled out here, probably just over three years ago, probably in the last 18 months we've really noticed it. Bulk billing psychologists, we used to have a few around. They've all moved into private practice, they don't do Medicare stuff anymore. OTs, any of those kind of, yeah, more specialised allied health services, there are none. There are no bulk billing ones available, because they've all moved into the private sector." (Mainstream Health Provider, Bundaberg & Hervey Bay)

- ***Limited post-treatment services:*** local stakeholders identified limited post-treatment follow up as a key challenge and contributor to relapse. In particular, the post-detoxification and post-rehabilitation period were considered crucial areas of follow-up, however, limited resources and funding means that services are restricted in the role they can play in following-up patients.

  "I think trying to frame we need to create realistic expectations in the community that for example, detoxification, that we need to moderate some of the expectations with just detoxification. It's more to do with what happens after that, we need to change the conversation, change the messaging, I think, to some degree, because it gets too simplistic at times, that somehow I can go away for four or five days and I don't have to do any more than that, then we need to change the conversation." (AOD Service Provider, Bundaberg & Hervey Bay)

Current workforce capacity - peer delivery, local service delivery: Some local stakeholders voiced that the AOD spaces, within Bundaberg specifically, were well staffed, in terms of overall numbers. Issues raised by local stakeholders around current workforce capacity were mostly focused on the lack of Aboriginal staff employed across AOD services.

However, other local stakeholders did express concerns around sufficient staffing. Specifically, commenting on workforce capacity, one Mainstream Health Representative highlighted the challenges associated with attracting workers to remote areas, and how outreach services have limited staff.

> *"There's only one service that goes out there [surrounding remote areas] and they only go out there once every two or three weeks and they're not culturally appropriate."* – (Mainstream Health Representative, Bundaberg & Hervey Bay)

Another local stakeholder expressed concern around quick staff turnover, explaining that staff, particularly Aboriginal staff, carry large work, life and cultural associated loads and are thus, prone to burning out.

> *"You got someone, it's all right, they're there. But then they burn out, then my mob we burn out because we got our own cultural loads at home."* (AOD Service Provider, Bundaberg & Hervey Bay)

Cultural safety and appropriateness for Aboriginal and Torres Strait Islander peoples: The majority of local stakeholders expressed concerns around the cultural safety and appropriateness of current AOD services. This was directly linked to the limited number of Aboriginal staff employed in AOD services, which was seen as essential in ensuring cultural safety and appropriateness. Further, local stakeholders explained that some services only include Aboriginal consultation as it may be a requirement, rather than genuinely intending to increase the cultural safety and appropriateness of their care.

> *"Then there's lots of services who just want to tick a box. They want to engage with [Aboriginal Controlled Organisations] so that they can tick off their reconciliation plan."* (ACCHO Representative, Bundaberg & Hervey Bay)

However, it was also acknowledged that services were beginning to improve in their efforts to provide culturally safe and appropriate treatment for Aboriginal patients.

> *"I think by the very nature of the fact that they want to work alongside us demonstrates that to some degree; they recognise that they need to be working from a really culturally safe perspective for their clients. There's lots of services who don't or think that they do, but aren't probably really well educated about what that looks like."* (ACCHO Representative, Bundaberg & Hervey Bay)

Some local stakeholders expressed concerns, however, around the cultural awareness training courses that non-Aboriginal staff are receiving, explaining that they are not sufficient at preparing staff to provide culturally safe and appropriate care for patients, specific to the local community.

> *"What's the political situation? What are the things that influence our people? What's the housing like? What's the dropout rate at school like? They're the culturally appropriate things they should know, not about calling somebody Uncle or Aunty or not looking them in the eye."* (Aboriginal Community Leader, Bundaberg & Hervey Bay)

Gaps and how might these be filled

Gaps in the provision of treatment services: Several gaps in the provision of AOD treatment services were identified by local stakeholders across the Bundaberg-Hervey Bay region:

- ***Rehabilitation Centre:*** A key gap identified throughout the interviews, specific to Bundaberg, was the lack of a local residential rehabilitation centre. Interviewees acknowledged that Queensland Health was currently building a local residential rehabilitation, but that this was not expected to open until 2022 or 2023.

- ***Men's and women's specific services:*** In addition, local stakeholders also identified the lack of men's specific and women's specific AOD treatment services as a major gap in engaging Aboriginal peoples in AOD treatment.
- ***Post-treatment:*** Limited AOD patient follow-up and formal, clear pathways which link AOD patients to post-treatment services were considered key contributors to treatment failure. In particular, post-detoxification follow-up was considered a major gap and contributor to limited uptake of rehabilitation.

  > *"Someone will go to detoxification and go on to rehabilitation, but there's a number of people who go to detoxification and for whatever reason, leave detoxification, continue with it, or will say, aspire to go to rehabilitation, they don't change their mind. So I think there'll be some people who could fall through the cracks that don't go from A to B. Some will go from A, and then drop off."* (Mainstream Health Provider, Bundaberg & Hervey Bay)

- ***Family-approach:*** Limited availability of post-treatment services which engage the entire family unit, was also raised as a gap in current treatment services. Limited services engaging the entire family were also considered a central contributor to the high rates of AOD relapses observed by local stakeholders.
- ***Holistic approach:*** Some local stakeholders perceived a gap in AOD treatment services' addressing other challenges that individuals may be struggling with, which may be significant drivers of their AOD use. One mainstream health provider felt it was important for rehabilitation services to also address mental health challenges, post-rehabilitation.

  > *"But I think we really lack appropriate rehabilitations that deal with the mental health and substance abuse as a whole, it's very siloed."* (Mainstream Health Provider, Bundaberg & Hervey Bay)

Gaps in cultural appropriateness of services for Aboriginal and Torres Strait Islander peoples: Gaps in the cultural appropriateness of services were highlighted as a key issue across the Bundaberg-Hervey Bay area. The limited number of Aboriginal staff employed across services was considered the major gap in the cultural safety and appropriateness of AOD services, but as this quote illustrates there are broader gaps in the integration of mental health and AOD treatment services into culturally aligned supports.

> *"Whilst we can always do with more increased detoxification and specific services, what we're really lacking is an effective integration of really effective mental health and drug and alcohol services, that are culturally together."* (Mainstream Health Representative, Bundaberg & Hervey Bay)

Further, one local stakeholder highlighted how limited Aboriginal staff and leadership contributes to gaps in the cultural appropriateness of services. Explaining how leaders who have significant ties to the community can succeed in these roles, especially leaders who have significant ties to the community, one stakeholder said:

> *"So, we need to really value our people with the skills and experience and, yeah, put them in the leadership roles. Because they will understand about the community more than someone that's only learnt about it in a book... Most times we have people that will say, I've worked in the Northern Territory or whatever, and it's just a big kick in the guts for someone that has experienced that community and has the qualifications, but they don't get a chance to lead the projects."* (AOD Service Provider, Bundaberg & Hervey Bay)

Gaps in workforce capacity to meet AOD treatment needs - peer delivery, local service delivery: The gaps in workforce capacity to meet AOD treatment needs were particularly centred around the lack of Aboriginal staff employed across AOD services, specifically local people.

When discussing outreach services, concerns were also raised around the limited number of staff available to travel to surrounding regional and remote communities, as well as high turnover rates of staff within regional and remote communities.

Additional service providers, services, and cooperatives filling gaps: Local stakeholders spoke about The Breakthrough for Families program filling the gap of providing family support for AOD treatment in the community.

Other types of support: The role of family was raised as a key AOD support for Aboriginal families in particular. This underscores the importance of AOD services taking a holistic approach to AOD treatment, acknowledging the role of the extended family.

How to fill gaps: Several methods to fill gaps were identified by local stakeholders.

Potential for scaling-up current provisions of services: The potential for scaling-up current services varied depending on the specific area of the local stakeholders.

In Bundaberg the perception was that there was a sufficient number of services, but that these services needed to be more culturally appropriate.

However, in Hervey Bay local stakeholders expressed the necessity of scaling-up AOD services.

> *"The problem in our district is, I don't think we have enough services here. There's Bridges and there's Queensland Health"* (AOD Service Provider, Hervey Bay)

Workforce capacity, continuity of service delivery, and sustainability - peer delivery, importance of community knowledge: When discussing outreach services, one Mainstream Health Representative highlighted the difficulties of finding qualified staff to work in remote and regional areas, but that increased funding may help to hire more staff.

> *"It's difficult to attract workers to those areas, but with an increased funding model, we could supply someone to go out there once a week and connect with the community with our Aboriginal Health Workers."* (Mainstream Health Representative, Bundaberg & Hervey Bay)

When considering the potential to scale up, it was also acknowledged that it may be initially challenging to find the sufficient workforce capacity, but one Mainstream Health Representative did feel that this was possible.

> *"Initially we'd probably struggle, but if we were helped to develop some sort of plan that allowed us to prepare our own people, I'm sure we'd get there."* (Mainstream Health Representative, Hervey Bay)

Regarding the gap in the employment of Aboriginal staff members, local stakeholders underscored that filling this gap must go beyond Aboriginal people being employed. Rather, services must prioritise and formalise ways to ensure Aboriginal staff members' voices are heard and reflected in service and treatment design and implementation. It was also suggested that upskilling local Aboriginal people may be an effective solution at increasing culturally appropriate workforce capacity.

> *"Or skilling up – or skilling up our mob. Make some traineeships, or apprenticeships for them so that they can get their qualifications in alcohol and drug – or, mental health workers, you know? Give them that incentive".* (AOD Service Provider, Bundaberg & Hervey Bay)

Further, one local stakeholder outlined the powerful impact of community engagement on increasing local workforce capacity. Specifically, this local stakeholder explained that health care workers sharing and explaining their work at local primary and high schools, has been an effective method in the past, in encouraging and empowering youth to learn more about the pathways to working in health care.

Guidance for the development of a grants programme

Lessons from past AOD approaches (what to and what not to replicate): Local stakeholders explained that transparency of funding and community engagement are important takeaways from past AOD approaches to be acknowledged in future grant funding programs.

> *"I mean, if there was a, like you said, like a funding framework around this stuff and there was better community engagement with the services and everyone was kept updated and aware of what was going on, then, yeah, I guess, it can work."* (AOD Service Provider, Bundaberg)

Challenges with past and current grant funding:

Local stakeholders raised strict reporting requirements as a significant challenge to do with past and current grant funding. Reporting requirements were perceived to be demanding, with quarterly reporting and meetings considered a significant time cost.

> *"The reporting is all based on what they [grant funding body] want, not very reflective of what we're doing, I don't think there's a lot of understanding of what happens on the ground, there's a whole lot of other things you do that aren't related to KPIs."* (ACCHO Representative, Bundaberg & Hervey Bay)

Another challenge raised was the specific deliverables that are set by the funding body, rather than the organisations themselves.

> *"Deliverables get set by the funding body, I feel very much that it should be coming from the people providing the service."* (ACCHO Representative, Bundaberg & Hervey Bay)

The competitive nature of grant funding applications was also highlighted as a key challenge, and a key driver of the lack of collaboration between organisations and services.

One local stakeholder also called for a more flexible funding model, explaining that a significant challenge with current grant funding models were that they are not tailored to working with Aboriginal and Torres Strait Islander communities, specifically:

> *"Just primarily, it doesn't recognise the complexity of the work that gets done in that it doesn't reflect the complexity of the Aboriginal Torres Strait Islander community as a whole. Again, it's based on white mainstream funding and what has worked in that area and in it, we know systemically it does not work for our community that model of care does not work. I think the challenge is trying to do what we know works with our community, within the resources and trying to be flexible under what we're funded to do, and what we also know needs to happen. So, I think definitely a more flexible funding model, but that also recognises the huge need for our outpatient cases, complex case management and outreach."* (Mainstream Health Provider, Bundaberg & Hervey Bay).

Potential issues with implementing grant funding and how to avoid these issues: The main issue with the implementation of grant funding, identified by local stakeholders included being able to appropriately attract staff to the region, given the difficulties associated with securing housing.

Additionally, the importance of collaboration between services and consultation with local stakeholders was considered essential to successful implementation.

Ensuring grant funding and program success (potential grant making processes and structures): Co-operation and collaboration between organisations applying for grant funding was considered key to ensuring grant funding

success. It was thought that if organisations work together in the initial stages of the grant application process, there will be little duplication and consequently, decreased competition for securing grants.

Further, flexibility and adaptability of funding to meet community needs was highlighted as a critical factor to grant funding and program success.

> *"I think just that flexibility and funding and allowing the programs to adapt to what the needs of the community are. So rather that we know that we funded for AOD but we also know that AOD doesn't work on its own. It is part of a bigger picture for every person you meet, and it may be a very small part of the picture, considering what else is happening for them."* (Mainstream Health Provider, Bundaberg & Hervey Bay)

> *"…so to be able to be flexible to run men's and women's programs that may not necessarily have a main focus of drug or alcohol. But as a big picture, we're working on cultural connectedness and cultural inclusivity that they're learning about their culture and who they're connected to and discussion and yarning and sharing stories and as part of that comes up. The drug and alcohol issues, being in jail, the trauma that they've gone through and for us it's kind of beautiful to watch at times because even though we don't set it up specifically just to address a drug and alcohol things. They kind of tap into the drug and alcohol problems…"* (Mainstream Health Provider, Bundaberg & Hervey Bay)

Conclusions and recommendations

In Bundaberg & Hervey Bay, local stakeholders have identified clear need for more and better AOD treatment services. Those services need to complement the planned Queensland residential rehabilitation, as well as post-treatment supports. Services also need to do a better job collaborating with each other and with ancillary organisations and community structures that can support people struggling with AOD use. In addition, there is also a clear need to improve the cultural appropriateness of all AOD treatment services in the community, which can be bolstered via supporting and extending services run by Aboriginal Controlled organisations. Stakeholders identified that future funding can support the growth and improvement of existing treatment services, but that there are also gaps that new services are likely better situated to provide, such as AOD treatment services run by Aboriginal Controlled organisations.

8. Recommendations

The recommendations here are based on the findings from the consultations and are designed to support the allocation of grant funding across the four CDC trial sites. In discussions with Commonwealth, state and local stakeholders we sought to understand more about the current gaps in the provision of AOD treatment services across the four CDC trial sites and where future grant funding could be applied to deliver positive outcomes.

Our nine recommendations focus on the treatment needs across the CDC trial sites, maximising the provision for vulnerable groups, workforce training and capacity building, enhancing localisation and collaboration in service provision, and the more tactical elements of the grant process.

Provision of specialist treatment

There is a broad need for an increase in specialist AOD treatment services across regional and remote Australia, with the needs of each CDC trial site specific to their local population. For example:

- In East Kimberley, stakeholders emphasised the need for greater access to 24hr services for AOD support, to ensure those receiving treatment are able to access it. This could be delivered via telephone and online services, however these services would need to be offered in a culturally safe way and require on-going local availability of appropriately qualified staff;
- In Goldfields, because of the remoteness of some of those requiring AOD treatment they would particularly benefit from an increase in outreach AOD treatment. Availability of appropriately qualified staff who are able to build trust with the community through continuous contact, both during and post-treatment, would be an important consideration for funding;
- In Ceduna, residents would benefit from access to a local residential rehabilitation service, as well as local post-treatment services. However, a four-year funding grant that does not address the challenge of recruiting an appropriately trained workforce, or how the service will be funded after the four-year period would have limited efficacy; and
- In Bundaberg-Hervey Bay, there is a need for greater provision of counselling and clinical care co-ordination services, as well as post-treatment services. However, the challenge of recruiting and retaining the appropriate workforce is part of the reason for a lack of provision of this service.

Recommendation 1: Funding to specialist treatment services should be tailored to the needs of each community.

Consideration of these area-specific needs as outlined throughout this report should be taken into account in funding specialist treatment in all four communities, however limited access to an appropriately qualified workforce, who can provide services in a culturally safe manner, needs to be addressed as it could present a barrier to the delivery of positive outcomes from the funding. It is important to note that Aboriginal and Torres Strait Islander community-controlled organisations should be involved in the provision of culturally safe services to Aboriginal and Torres Strait Islander peoples.

Ensuring key groups are provided for

There is a need to consider the provision of services for younger people in the community, as well as gender-specific, family, culturally safe, and Aboriginal & Torres Strait Islander-led services. There is a need for these types of tailored services in all four CDC trial sites to different degrees, shaped by the availability of staff who can be appropriately matched to those receiving treatment.

Recommendation 2: Funding should be provided to meet the specific needs of population specific sub-groups.

Grant applications that consider the needs of specific sub-groups within each local population should be considered carefully in light of the detailed findings from each area in this report, but also in consultation with people from the local community. In particular by community-controlled organisations who are led by and accountable to local Aboriginal and Torres Strait Islander communities. However, in settings where there are multiple Aboriginal and Torres Strait Islander groups this may include ensuring mainstream services are able to provide culturally safe services to all groups.

Training and capacity-building

As noted previously, the challenge of accessing an appropriately qualified workforce is not unique to the four CDC trial sites; it is a problem facing the AOD treatment sector and rural and remote Australia. There are a number of layers to the challenge of attracting and retaining an appropriate workforce that require attention. For example, in East Kimberly, Goldfields and Ceduna the challenge is a lack of housing and infrastructure for those who might move to the area. In Bundaberg-Hervey Bay it is the cost of housing that is a barrier.

There is a need for people in the local area with appropriate clinical skills, however there is also a need for local people to be encouraged and supported to obtain these skills. It may be appropriate for organisations with more experience to coach and support locals, including those from Aboriginal and Torres Strait Islander backgrounds, to perform key roles and obtain qualifications, for example ACCHOs. It will be important to embrace Aboriginal and Torres Strait Islander people-led provision of culturally safe services in terms of their understanding of the local community and cultural safety, while also provide observation and guidance to ensure the treatment offered is based on clinical evidence. It was also noted that short-term grant funding made it more difficult to offer certainty of employment when advertising roles.

Recommendation 3: Prioritise grant applications with a strong training and capacity development focus.

Grant applications that build the capacity of local people to become the future of the AOD treatment workforce and include plans to attract and retain qualified people and should be prioritised. This is particularly relevant for developing the capacity of local Aboriginal and Torres Strait Islander workforce in each area.

Recommendation 4: Provide longer term funding agreements to support workforce development.

The time period covered by the funding granted should also be maximised to make service provider roles in each location as attractive as possible to prospective employees, as well as enhance impact of service delivery on the local community.

Enhancing the ability of local services to be delivered via outreach in community

Across the four CDC trial sites there was a desire for services to be offered, where appropriate, at the point of need, instead of at a clinical site or central location chosen for logistical reasons. In addition to better meeting the needs of individuals this approach would also tackle the financial barriers created by travel for treatment.

These needs were associated with a desire for increased outreach service provision. Outreach presented an opportunity for service providers based in the local community to take services out to remote communities. However, it was noted that outreach was best delivered by those with links to the community, or with a community broker, and that for successful outcomes those tasked with delivering outreach should be established in the local area. However, given the shortage of an appropriately qualified workforce this may be problematic.

Recommendation 5: Increase funding for outreach services.

Grant applications that plan to deliver services via an outreach model, or that extend a current outreach service should be prioritised. However, in such applications the availability of an appropriately qualified and local workforce should be considered.

Collaboration between service providers

Across all four CDC trial sites it was recognised that there are strong benefits to be gained from partnerships between AOD treatment services and other local health and social service providers, such as family and domestic violence services or homelessness services. Capacity-building to further facilitate these partnerships would be of benefit.

Enhanced collaboration was also considered a key part of the response to demand for Person-centred/Case management styles of care.

An extension of this need relates to access to education and training, good quality housing and employment support. Although interventions in these areas are not directly related to AOD treatment, all stakeholders were clear that support for these social determinants of health were an important factor in the delivery of positive outcomes.

Recommendation 6: Encourage meaningful collaboration between service providers.

Grant applications that enhance or initiate collaboration between service providers, with a focus on treating the individual and supporting all areas of their life (including family, culture, employment, education, and housing) should be prioritised.

It is important to note that the Priority Reforms of the National Agreement on Closing the Gap, particularly Priority Reforms 1 and 2, prioritise equal partnerships and shared decision-making with Aboriginal and Torres Strait Islander peoples, and building the community-controlled sector. This will need to be considered and reflected in the structure of any collaborations proposed or put forward by service providers in the communities.

Engaging with, and understanding, local delivery partners

There is a desire from local communities to be part of activities that contribute to AOD treatment, which includes activities that provide an alternative to AOD consumption and those that continue to provide support while an individual is receiving treatment from a clinical partner. Another aspect of this was the desire for gaps in services to be filled by ACCOs with a focus on providing culturally safe/appropriate services, which are of benefit to different groups throughout local communities.

It is clear that there is a strong desire for NIAA and, in Ceduna and East Kimberly, Empowered Communities to ensure that the voice of the community is included in the grant review process. There is also a desire from state-based health providers that they too have a voice in the prioritisation of initiatives. By including local voices, services can be better prioritised.

It was also noted that evidence-based treatment decisions should be shared with communities so that it can inform community and government joint decisions on how to meet community and government priorities.

Recommendation 7: Involve community and inter-governmental stakeholders in grant development and assessment processes.

In light of a desire from a range of local stakeholders to have the opportunity to not only ensure services are informed by clinical evidence of what works, but consider the specific needs of the community, and ensure that they are delivered in a culturally safe and person-centred way, it would be beneficial for grant submissions to consider how they might meet these three criteria in their bid. It may also be appropriate for the body reviewing grant applications to include NIAA, Empowered Communities and state-based AOD representatives.

Recommendation 8: Include local stakeholders in feedback and continuous development of grant recipients

The possibility of discussing and agreeing community-based KPIs or other accountability metrics into those grants awarded could also be considered.

Administering a grant process for maximum positive outcomes

There is concern that a grants process can present barriers to participation for some service providers. This may relate to the requirement for insurance, a focus on KPI measurement, timelines or a perceived lack of transparency. It was noted that grant application processes have often been developed to ensure that crucial quality standards are met, and this should not be dismissed, but it may lead to scenarios where local services providers, who have the potential to deliver positive outcomes, miss out on the opportunity.

Recommendation 9: Local organisations should be prioritised for funding.

Grant applications from organisations embedded in a specific CDC trial site community, or led by local organisations should be prioritised. This could include prioritising ACCHO-led proposals or consortia proposals that include ACCHOs, in alignment with principled commitments in the National Agreement on Closing the Gap. Those that include a partnership should also consider how investment could be used to build the capacity of the local organisations to make successful grant applications in the future.

Appendix A Figure explanations

Table 2

Page 1	
Component	**Description**
Title	Executive summary Part one: Overview of consultation, community AOD needs, current provision of AOD treatment service and gaps
Background	In 2016, the Australian Government began a staged implementation to the roll out of the Cashless Debit Card (CDC) to ensure that welfare payments are spent in responsible and meaningful ways by restricting the use of income support payments to purchase alcohol, illicit drugs or gambling products. In the 2021-22 Budget, the Federal Government announced funding of $49.9 million over four years to establish and support alcohol and other drug treatment services for the CDC sites of Ceduna, East Kimberley, the Goldfields and Bundaberg & Hervey Bay Regions.
Consultation approach	Fiftyfive5 and CIRCA were commissioned to conduct the consultation to inform decisions on expenditure to establish new and support existing alcohol and other drug treatment services for each of the four CDC sites. Phase 1: Alignment: • REA • Interviews with expert stakeholders Phase 2: Consultations: • 47 x Local community stakeholders • 25 x Commonwealth funding bodies, PHNs, State Health departments and non-governmental agencies
Community AOD needs	Stakeholders described a complex interplay of the social and health issues that are central to problematic AOD use. There were many consistencies in the social and health issues across the four CDC locations, notably homelessness, unemployment, intergenerational trauma, racism/discrimination, poverty and comorbid mental health problems. Homelessness and lack of affordable housing was a particular issue identified, with this seen to perpetuate AOD problems. The specific AOD needs also varied between locations, with drug use considered more problematic in some areas, and health and social issues presenting notable concerns in others.
Key gaps in current service provision	All regions identified strong benefits from increased investment in AOD treatment services. However, there were also region-specific needs identified. Bundaberg and Hervey Bay: • **Gaps**: Rehabilitation centre (one opening 2022/23); counselling clinical care co-ordination services, post-treatment services Ceduna: • **Gaps**: Residential rehabilitation centre; detoxification services and post-treatment services East Kimberley: • **Gaps**: Out of hours services Goldfields: • **Gaps** : Prevention services, cohort-specific services (i.e., youth and women), outreach services

Page 1	
Component	**Description**
Page 2	
Title	Executive summary Part two: AOD service gaps, guidance for development of a grant programme and recommendations
Gaps	Although each CDC location has distinct AOD current service provision and needs, the gaps in service delivery predominantly relate to four main areas • General AOD treatment services: All areas had limited access to in-patient rehabilitation, as well as need for outreach in all areas • Targeted AOD treatment services: Lack of services supporting the needs of specific groups, particularly Aboriginal and Torres Strait Islanders peoples, youth and women • Workforce: All areas identified workforce gaps, notably lack of Aboriginal staff and difficulty attracting qualified staff. Local issues are outlined in the report • Infrastructure: Services cannot address AOD issues without also addressing basic needs. Demand for access to employment and housing services was high in all areas
How to fill the gaps…	• Scaling-up current provisions of services • Greater levels of interagency collaboration and communications • Training and capacity building • Local engagement and community-led decision making
Success with grant funding	• Localised approach that is informed with local knowledge • Driven by community need • Delivered or partnered with local service providers • Builds capacity of local service providers • Community engagement and decision making • Appropriate length of funding
Downfalls with grant funding	• Restricted grant funding application process • Strict grant monitoring and reporting (i.e., KPIs) • Short-term nature of funding • Duplication • Vast regions for service delivery
Key finding box	Given the unique characteristics and needs of each CDC region, grant funding will need to be localised and targeted to each region. However, stakeholder suggestions related to the parameters and requirements of a grant program are consistent and can be applied across all four locations.
Page 3	
Title	Executive summary Part three: Recommendations and conclusions
Key finding box	Our nine recommendations focus on the treatment needs across the CDC trial sites, maximizing the provision for vulnerable groups, workforce training and capacity building, enhancing localisation and collaboration in service provision, and the more tactical elements of the grant process.
Recommendations	**PROVISION OF SPECIALIST TREATMENT** 1. Consideration of area-specific needs should inform grant funding of specialist treatment in each location

Page 1	
Component	**Description**
	ENSURING KEY GROUPS ARE PROVIDED FOR 2. Prioritise grant applications that consider specific sub-groups needs and fund tailored services (i.e., youth, gender-specific, family, culturally safe, and Aboriginal & Torres Strait Islander-led services-led services), as well as grants that ensure appropriate staffing **TRAINING AND CAPACITY-BUILDING** 3. Given the need for appropriate staffing, precedence should be given to grant applications with plans to attract and retain qualified staff or build the capacity of local people, notably those who identify as Aboriginal & Torres Strait Islander 4. Long-term grant funding may increase attraction of grants to service providers, facilitate recruitment of appropriate staff, as well as enhance impact of service delivery on the local community **ENHANCING THE ABILITY OF LOCAL SERVICES TO BE DELIVERED IN COMMUNITY** 5. Due to the desire for AOD services to be delivered at the point of need, grant applications that provide an outreach service, or offer to extend a current outreach service should be prioritised. **COLLABORATION BETWEEN SERVICE PROVIDERS** 6. Grants that initiate or enhance systems to enable collaboration between service providers should be prioritised **ENGAGING WITH, AND UNDERSTANDING, LOCAL DELIVERY PARTNERS** 7. Grants should consider how they meet criteria (informed by evidence; consideration of local need; culturally safe and person-centred). Inclusion of NIAA, Empowered Communities and state-based AOD representatives in review of grant applications would be beneficial 8. Consider building KPIs or other accountability metrics into grants awarded to allow community stakeholders to appraise the performance of a provider **ADMINISTERING A GRANT PROCESS FOR MAXIMUM POSITIVE OUTCOMES** 9. Grant applications from local community organisations that led or act as a partner for the service delivery should be prioritised. In particular, any grants that incorporate capacity building of local services

Table 3

The table below contains the content of the Demographic Overview of Ceduna figure, as shown in the body of this report.

Component	Description
Geographical area	5,424 km²
Total population	2,550
Gender	51% Female; 49% Male
Median age	38 years
Those who identify as Aboriginal and Torres Strait Islander	20%
Those that speak a language other than English at home	8%
Median weekly rent	$186
Median weekly household income	$1,254

Component	Description
Employment	59% Full-time employment; 29% part-time employment; 9% away from work; 3% unemployed
Education	9% Bachelor Degree level & above; 6% Advanced Diploma & Diploma level; 3% Certificate level IV; 14% Certificate level III; 12% Year 12; 12% Year 11; 13% Year 10; 12% Year 9 or below

Table 4

The table below contains the content of the Demographic Overview of East Kimberley figure, as shown in the body of this report.

Component	Description
Geographical area	263,908 km²
Total population	7,148
Gender	51% Female; 49% Male
Median age	33 years
Those who identify as Aboriginal and Torres Strait Islander	33%
Those that speak a language other than English at home	10%
Median weekly rent	$196
Median weekly household income	$1,704
Employment	68% Full-time employment; 18% part-time employment; 7% away from work; 7% unemployed
Education	14% Bachelor Degree level & above; 7% Advanced Diploma & Diploma level; 3% Certificate level IV; 14% Certificate level III; 13% Year 12; 6% Year 11; 13%Year 10; 7% Year 9 or below

Table 5

The table below contains the content of the Goldfields figure, as shown in the body of this report.

Component	Description
Geographical area	771,276 km²
Total population	39,097
Gender	53% Female; 47% Male
Median age	33 years
Those who identify as Aboriginal and Torres Strait Islander	12%
Those that speak a language other than English at home	14%
Median weekly rent	$250
Median weekly household income	$1,980

Component	Description
Employment	67% Full-time employment; 20% part-time employment; 6% away from work; 6% unemployed
Education	11% Bachelor Degree level & above; 6% Advanced Diploma & Diploma level; 3% Certificate level IV; 17% Certificate level III; 14% Year 12; 7% Year 11; 15%Year 10; 8% Year 9 or below

Table 6

The table below contains the content of the Demographic Overview of Bundaberg and Hervey Bay figure, as shown in the body of this report.

Component	Description
Geographical area	3,818 km²
Total population	141,716
Gender	51% Female; 49% Male
Median age	46 years
Those who identify as Aboriginal and Torres Strait Islander	4%
Those that speak a language other than English at home	6%
Median weekly rent	$275
Median weekly household income	$946
Employment	51% Full-time employment; 33% part-time employment; 5% away from work; 11% unemployed
Education	10% Bachelor Degree level & above; 7% Advanced Diploma & Diploma level; 3% Certificate level IV; 17% Certificate level III; 13% Year 12; 5% Year 11; 18%Year 10; 12% Year 9 or below

Table 7

The table below contains the content of the Demographic overview of the CDC participant population figure, as shown in the body of this report.

Component	Region	Description
Gender	Ceduna	53% Female; 47% Male
	East Kimberley	60% Female; 40% Male
	Goldfields	58% Female; 42% Male
	Bundaberg and Hervey Bay	57% Female; 43% Male
Type of Government Payment	Ceduna	53% Newstart Allowance; 11% Parenting Payment Single; 19% Disability Support Pension; 4% Carer Payment; 7% Youth Allowance; 4% Parenting Payment Partnered
	East Kimberley	43% Newstart Allowance; 19% Parenting Payment Single; 23% Disability Support Pension; 5% Carer Payment; 5% Youth Allowance; 6% Parenting Payment Partnered
	Goldfields	48% Newstart Allowance; 19% Parenting Payment Single; 18% Disability Support Pension; 6% Carer Payment; 5% Youth Allowance; 3% Parenting Payment Partnered
	Bundaberg and Hervey Bay	40% Newstart Allowance; 24% Parenting Payment Single; N/A Disability Support Pension; N/A Carer Payment; 24% Youth Allowance; 6% Parenting Payment Partnered
Identify as Aboriginal and Torres Strait Islander	Ceduna	74%
	East Kimberley	82%
	Goldfields	46%
	Bundaberg and Hervey Bay	No data available
Housing	Ceduna	38% Public housing; 18% Renting; 38% Boarding; 6% Other

Component	Region	Description
	East Kimberley	52% Public housing; 7% Renting; 35% Boarding; 6% Other
	Goldfields	31% Public housing; 30% Renting; N/A Boarding; 39% Other
	Bundaberg and Hervey Bay	No data available

Table 8

The table below contains details of the AOD services providing services available in the Ceduna region.

Organisation	Service	Primary Treatment / Support Type	Address
Aboriginal Drug & Alcohol Council of SA Incorporated	Ceduna Drug and Alcohol Day Centre - Stepping Stones Day Centre	Day centre	3 Kuhlmann St, Ceduna SA 5690
Aboriginal Drug and Alcohol Council (SA) Aboriginal Corporation	SA Measure - Ceduna Service Collaboration: Clinical AOD Alliance	A multi-sector collaboration that aims to improve safety and wellbeing outcomes for vulnerable Aboriginal people in and around Ceduna through the delivery of effective and integrated services and a human services system that is community-centred, locally driven	NA
Drug and Alcohol Services South Australia	Outpatient counselling	Counselling	Ceduna District Hospital, 3 Eyre Highway, CEDUNA, SA, 5690
Life Without Barriers	Alcohol and Other Drugs	One-on-one Individual Outpatient Counselling Services	3/8 Drew St, Thevenard SA 5690
Life Without Barriers	Drug and Alcohol Counselling Service	Case Management	3/8 Drew St, Thevenard SA 5690 (Outreach)
Street Beat MOBILE ASSISTED PATROL	Mobile Assistance Patrol	Transport to home, sobering up and other services	
Tullawon Health Service Incorporated	Tullawon AOD Service	Assessment and referral SEWB/AOD program	303 Tullawon Sq, Yalata SA 5690
Yadu Health Aboriginal Corporation	AOD and Mental Health Service	Case Management, Care Planning and Coordination	1 Eyre Hwy, Ceduna SA 5690
Yadu Health Aboriginal Corporation	Sobering Up Unit	Sobering Up Service	1 Eyre Hwy, Ceduna SA 5690

Table 9

The table below contains details of the AOD services available in the East Kimberley region. This list covers AOD specific services being delivered within the East Kimberley region (those certified as per the National Quality Framework for AOD Treatment (NQF) and which receive government funding specifically for the provision of AOD services).[19]

Organisation	Service	Primary Treatment / Support Type	Address
Anglicare WA (lead organisation: Ngnowar Aerwah)	AOD support services Wyndham	Counselling	Anglicare Wa, 2 Banksia St, Kununurra WA 6743
Garl Walbu Aboriginal Corporation	Derby Sobering Up Centre	Sobering Up Service	13 Stanley St, Derby WA 6728 **(West Kimberley)**
Kimberley Alcohol and Other Drug Services- Milliya Rumurra Residential Rehabilitation	Milliya Rumurra Aboriginal Corporation	Residential Rehabilitation	78 Great Northern Hwy, Broome WA 6725 **(West Kimberley)**
Kununurra Waringarri Aboriginal Corporation	Moongoong Sober Up Shelter	Sobering up	2229 Speargrass Rd, Kununurra WA 6743
Milliya Rumurra Aboriginal Corporation	Specialist AOD Treatment Services for Broome	Outpatient counselling WA Diversion Program Cannabis Intervention Sessions Alcohol Interlock Sessions, AOD residential rehabilitation service	78 Great Northern Hwy, Broome WA 6725 **(West Kimberley)**
Milliya Rumurra Aboriginal Corporation	Broome Sobering Up Centre	Sobering Up Service	78 Great Northern Hwy, Broome WA 6725 **(West Kimberley)**
Milliya Rumurra Aboriginal Corporation	Post Rehabilitation Continuing Care Service Kimberley	Aftercare & Relapse Prevention	8 Banksia Street, Kununurra WA 6743; 78 Great Northern Hwy, Broome WA 6725
Ngnowar Aerwah Aboriginal Corporation	Specialist AOD Treatment Services Wyndham	Case Management, Care Planning and Coordination	471 Great Northern Hwy, Wyndham WA 6740
Ngnowar Aerwah Aboriginal Corporation	Wyndham Sobering Up Centre	Sobering Up Centre	471 Great Northern Hwy, Wyndham WA 6740
Ngnowar-Aerwah Aboriginal Corporation	Seven Mile Rehabilitation Centre in the East Kimberley	Residential Rehabilitation	471 Great Northern Hwy, Wyndham WA 6740
WA Council on Addictions t/a Cyrenian House and Milliya Rumurra Aboriginal Corporation.	CHMR	Counselling	920 Gnangara Rd, Cullacabardee WA 6067 **(West Kimberley)**
WA Country Health Service	Kimberley Community Alcohol and Drug Service (KCADS)	Counselling and additional services	96 Coolibah Dr, Kununurra WA 6743

[19] Please also note that the Community Alcohol and Drug Services (CADS), which is the primary AOD non-residential service in the East Kimberley region is currently out for tender. The outcome of this tender will likely by known in late Q1/early Q2 2022 and may result in changes to service provider and service delivery.

Table 10

The table below contains details of the AOD services available in the Goldfields region. This list covers AOD specific services being delivered within the Goldfields region (those certified as per the National Quality Framework for AOD Treatment (NQF) and which receive government funding specifically for the provision of AOD services).[20]

Organisation	Service	Primary Treatment / Support Type	Address
Bega Garnbirringu Health Service	Kalgoorlie Sobering Up Centre	Sobering Up service	6-18 MacDonald St, Kalgoorlie WA 6430
Goldfields Rehabilitation Service Inc	Goldfields Rehabilitation Service - Kalgoorlie	Residential Rehabilitation	11 Porter St, Kalgoorlie WA 6430
Goldfields Rehabilitation Services Inc	Mental Health and Drug and Alcohol Treatment Services for the Kalgoorlie-Boulder, Coolgardie and Kambalda area	Case Management, Care Planning and Coordination	11 Porter St, Kalgoorlie WA 6430
Hope Community Services	Drug and Alcohol Treatment Services – Esperance, Leonora and Laverton	Treatment and prevention activities	Suite 1B/75-79 Dempster St, Esperance WA 6450; 307 Marine Terrace, Geraldton WA 6530; Shop 2, 72 Tower Street Leonora WA 6438;

Table 11

The table below contains details of the AOD services available in the Bundaberg-Hervey Bay region[21].

Organisation	Service	Primary Treatment / Support Type	Address
Bridges Health and Community Care	Bridges Withdrawal Management and Day Rehabilitation	Non-residential rehabilitation Counselling	River Terrace & Oconnell St, Bundaberg West QLD 4670
Bridges Health and Community Care	Wide Bay AOD Treatment Service	Case Management, Care Planning and Coordination	River Terrace & Oconnell St, Bundaberg West QLD 4670; 6/65 Main St, Pialba QLD 4655;
Bridges Health and Community Care	Regional, Rural and Remote Service expansion	Counselling	Agnes Water
Galangoor Duwalami (Maryborough)	Galangoor Duwalami_Social and Emotional Wellbeing	Counselling, OST, Withdrawal management (outpatient)	7/11 Central Ave, Pialba QLD 4655
Gindaja Treatment And Healing Indigenous Corporation	Drug and Alcohol Treatment Services	Residential Rehabilitation (State-wide service intake)	Back Beach Road, Yarrabah, Queensland

[20] Please also note that the Community Alcohol and Drug Services (CADS), which is the primary AOD non-residential service in the Goldfields region is currently out for tender. The outcome of this tender will likely be known in late Q1/early Q2 2022 and may result in changes to service provider and service delivery.

[21] qnada maintains a service directory of AOD services that provides a useful reference for the most up-to-date information on the availability of AOD treatment in the CDC region https://qnada.org.au/service-finder/

Goldbridge Rehabilitation Services	Goldbridge Drug and Alcohol Treatment Services Project	Residential Rehabilitation (State-wide service intake)	6A/9 Frinton St, Southport QLD 4215
Gumbi Gumbi	Gumbi Gumbi Withdrawal Management	Withdrawal management	25 George St, Rockhampton QLD 4700
Gumbi Gumbi	Gumbi Gumbi Residential Rehabilitation	Residential rehabilitation (State-wide service intake)	25 George St, Rockhampton QLD 4700
Indigenous Wellbeing Centre Bundaberg	Indigenous Wellbeing Centre AOD Counselling	Counselling	184 Barolin St, Bundaberg Central QLD 4670
Indigenous Wellbeing Centre Bundaberg	Indigenous Wellbeing Centre - Alcohol and other Drugs Program	Early Intervention	184 Barolin St, Bundaberg Central QLD 4670
Lives Lived Well	Regional, Rural and Remote Service expansion	Counselling	Mindcare Building, 147 Goondoon St, Gladstone Central QLD 4680
Lives Lived Well Limited	Logan House Assessment and Aftercare Program	Residential Rehabilitation (State-wide service intake)	75 Kirk Rd, Chambers Flat QLD 4133
The Salvation Army (Qld) Property Trust	Brisbane Recovery Services Community Detoxification Unit	Withdrawal Management and Residential Rehabilitation	58 Glenrosa Rd, Red Hill QLD 4059
The Salvation Army (Qld) Property Trust	Fairhaven Women's Extended Care Program	Withdrawal Management and Residential Rehabilitation	168 MacDonnell Rd Eagle Heights QLD 4271 Australia
We Help Ourselves	WHOS Sunshine Coast (Najara)	Residential Rehabilitation	404 Image Flat Rd, Nambour QLD 4560
WHOS Najara	WHOS Najara Nurse Liaison Initiative - Residential Withdrawal	Withdrawal management	404 Image Flat Rd, Nambour QLD 4560
Alcohol and Other Drugs Service Bundaberg	Alcohol and Other Drugs Service Bundaberg	Harm reduction, counselling, OST, withdrawal management (outpatient)	312 Bourbong St, Bundaberg, QLD 4670
DrugARM	Street Outreach Services	Counselling	Mobile outreach service
Lives Lived Well – Wunya	Lives Lived Well – Wunya	Residential Rehabilitation	55 Lower King St, Caboolture, QLD

Appendix B References in the core report

Central Queensland, Wide Bay, Sunshine Coast PHN (2019). Needs Assessment Report 2019 - 2022

Country SA PHN (2019). Needs Assessment Report 2019 - 2022

Country WA PHN (2019). Needs Assessment Report 2019 - 2022

Mental Health Commission (2019) Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, Plan Update 2018

Mental Health Commission (2020) Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020-2025

National Drug Research Institute at Curtin University (2014). Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions

ORIMA Research (2017). The Cashless Debit Card Trial Evaluation

Turning Point (2014). A study of patient pathways in alcohol and other drug treatment

South Australian Network of Drug and Alcohol Services (2018) South Australian Specialist Alcohol and Other Drug Treatment Service Delivery Framework

University of Adelaide (2021). Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields (the consolidated report, the qualitative supplementary report and the quantitative supplementary report)

University of Adelaide (2021). Independent baseline data collection in the Bundaberg and Hervey Bay region: Qualitative Findings report and Quantitative Data Snapshot

Department of Health

Rapid Evidence Assessment:
Consultation to Inform Funding for Alcohol and Other Drug Treatment Services to Support CDC Trial Participants

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30 September 2021

Documents reviewed

The purpose of the Rapid Evidence Review was to ensure that consultation plans for this report were informed by previous work, and to ensure the learning from that work informed the discussions with stakeholders and community representatives.

Section reference	Document name	Responsible party	Year of publication
1.1	The Cashless Debit Card Trial Evaluation	ORIMA Research	2017
1.2	Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields (the consolidated report, the qualitative supplementary report and the quantitative supplementary report)	University of Adelaide	2021
1.3	New Horizons: The review of alcohol and other drug treatment services in Australia	National Drug and Alcohol Research Centre at UNSW	2014
1.4	Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions	National Drug Research Institute at Curtin University	2014
1.5	A study of patient pathways in alcohol and other drug treatment	Turning Point	2014
1.6	National Ice Action strategy	Council of Australian Governments	2015
1.7	Final report of the National Ice taskforce	Council of Australian Governments	2015
1.8	National drug strategy 2017-2026	Department of Health	2017

1.1 The Cashless Debit Card Trial Evaluation

The first evaluation of the Cashless Debit Card Trial (CDCT) was run by ORIMA Research in 2017. The objective of the evaluation was to assess the effectiveness of the CDCT against a list of Key Performance Indicators (KPIs). The evaluation utilised both quantitative and qualitative research methodologies as well as a review of administrative data. It is important to note that the evaluation was primarily concerned with the Card itself and only superficially reported on the related alcohol and other drug treatment services provided.

The table below outlines learnings from the evaluation that are of relevance to the current study, and implications to consider for the design of the current consultation.

LEARNING	IMPLICATION
The evaluation reported that services that included non-local/non-Indigenous services and staff had more limited success in the delivery of Indigenous-targeted services. This was attributed to a lack of knowledge and understanding of local community dynamics and culture, as well as a lack of pre-existing relationships, which limited trust and credibility of the services.	Interviews with Indigenous community leaders, service providers and stakeholder representatives will be conducted one-on-one by CIRCA's local Aboriginal Consultants, in-person if COVID-19 restrictions allow.

LEARNING	IMPLICATION
It stressed the importance of consideration of cultural needs in CDC Trial sites – including the use of local Indigenous staff and organisations for services targeted at Indigenous Trial participants. Similarly, using non-Indigenous facilitators to consult with Indigenous community leaders, service providers and stakeholders' risks compromising consultation outcomes.	This approach guarantees the highest level of cultural safety to consultation participants. In-person consultations, conducted by Aboriginal and Torres Strait Islander peoples, allows our researchers and consultation participants the ability to converse with one another easily and freely.
The evaluation found that there was limited uptake and usage of the services funded through the CDC Trial. CDC participants reported higher intention to use services, but this did not translate to actual use. Similarly, stakeholders had expected an increase in service uptake but reported that no actual increase was observed.	It will be important to explore whether uptake has increased since the evaluation in 2017 and what barriers are still in place for CDC participants in relation to accessing the provided services.
Trial funding was reported to be allocated for very narrowly defined criteria and resources (e.g. rehabilitation and drug and alcohol counselling). The Evaluation reported that many of these resources had been underutilized.	The breadth of services available and those considered to be most desirable will need to be further examined as part of this consultation process.
Funding rules had been inflexible, not allowing for partnership and not allowing funding to be reallocated to adapt services to the local need.	This consultation process will seek to uncover potential partnership arrangements that would be considered appropriate by stakeholders.
Short-term funding arrangements limited the ability of services to achieve positive and sustainable outcomes.	This consultation process should consider service time frames as an area for further investigation.
The evaluation noted that support services funded through the Trial had not been implemented in a timely manner. This had negative impacts on people being able to access the services as well as reflecting poorly on community leaders who had "promised" that such services would be available when the Trial commenced.	It is important to ensure that expectations of community leaders and other stakeholders are managed throughout the consultation process to maximise the likelihood of positive outcomes.
Some stakeholders felt that communication of the availability and range of additional support services funded through the Trial, amongst Trial participants as well as service providers, had not been effective or sufficient which had contributed to a lack of service uptake and referrals.	The current state of communications needs to be explored as well as preferred methods of communication for the future.
Location was identified within the evaluation as being a major barrier for many with regards to accessing CDC related support services in a timely manner. A few stakeholders and community leaders in very remote communities reported that outreach services visited infrequently (e.g. every two months), which reduced the number of clients they could serve and their ability to build relationships with clients/potential clients.	Issues of access related to location will need to be further investigated, including how frequently outreach services are visiting very remote communities within each of the regions. We also need to ensure that our researchers consult stakeholders outside of the metropolitan areas.

1.2 Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields

A second evaluation of the Cashless Debit Card (CDC) was run by Future of Employment and Skills Research Centre at the Faculty of the University of Adelaide. The evaluation began in 2018 with the majority of the evidence collected in 2019 and the final paper published in early 2021. The evaluation utilised both quantitative and qualitative research methodologies, as well as administrative data provided by the government. The purpose of the evaluation was to create a new, integrated evidence base and use it to assess the impact of the CDC.

The table below outlines learnings from the evaluation that are of relevance to the current study as well as potential implications.

LEARNING	IMPLICATION
There was low awareness of support services designed to support the effectiveness of the Card. Many respondents (especially CDC participants) expressed a lack of awareness of any additional support services that had been funded under the umbrella of the CDC in their locations.	It will be important to explore what channels are having cut through in terms of awareness and suggestions for how to increase awareness. We will need to ensure that we include both those aware and those unaware of the support services within our participant base.
Some of those respondents aware of the allocation of CDC funding to support services, expressed concerns that these funds had not been well targeted. There was concern by many respondents that funding of broader support services (such as drug and alcohol rehabilitation, mental health and counselling services) designed to work alongside the CDC and effectively address the issues causing social harm, had not been realised.	It is important to explore how members of the community envisage these support services working in order to fulfil the aim of addressing the issues causing social harm.
Some stakeholders reported a lack of co-ordination in the way funding for support services was arranged. It was noted that this had impacts on areas such as staffing within the support services.	As part of our investigation we will need to explore how community members would see this working more efficiently in the future.
Disappointment was expressed by some respondents who perceived that the agreed funding of support services to run alongside the CDC had not occurred to a sufficient extent. Respondents reported a need for improvement to these support services and policy measures within the three CDC trial sites.	Further inquiry is needed into what improvements people within the community would suggest.
The evaluation notes that one of the key drivers of CDC being trialed in the East Kimberley region was a request from a select number of Aboriginal Leaders for some sort of intervention following an identified need for an alternative approach to curb the evident social harm. It also notes that these leaders requested certain conditions sit around the CDC, the first of which being support services. These services were considered to be of great importance as the leaders believed that the CDC would not be enough on its own to reduce the social harm that was being generated by substance misuse. A second condition set by the leaders was that they themselves had a significant say in which support services would be funded.	It will be important in the East Kimberly region to ensure we speak to leaders who have had an impact on the CDC being trailed in their community. We will also need to ensure we explore whether the correct services are being funded and what changes these leaders (and others within the community) think would have the greatest impact on support services.

LEARNING	IMPLICATION
A majority of respondents (especially stakeholders) reported during the qualitative portion of the evaluation that they expected social conditions within the region to worsen if the CDC trial ended and the funding for associated support services ceased.	As we know that funding for support services has been extended beyond the time of the trial it will be important to investigate how community members feel about this and what concerns (if any) they may have about the support services outlasting the CDC trial.
Respondents highlighted current gaps in support services and expressed a view that these services would benefit from additional resourcing. Furthermore, it was suggested that there was a need for agencies to better work together to develop appropriate localised responses to the complex social issues within the region.	Further examination of the specific "gaps" in support services, and inter-agency co-operation, is needed to better understand how funds can be appropriately allocated in the coming years.
Further community consultation is not only welcomed but desired by those living within the CDC trial sites. Views and concerns had been raised regarding a perceived lack of broad community consultation prior to the implementation of the CDC. Some of the evaluation respondents suggested that it was not too late for further consultation, both with stakeholders and community members, to inform future decisions about the CDC and funding for associated support services.	It will be important to ensure that community members and stakeholders understand that the consultation we are undertaking relates only to the support services and not the CDC itself. This is crucial for focusing conversations and for setting expectations for those involved.

1.3 New Horizons: The review of alcohol and other drug treatment services in Australia

The New Horizons Review by the National Drug and Alcohol Research Centre at UNSW, notes that Australia's approach to responding to the harms associated with alcohol and other drugs comprises the three pillars of the National Drug Strategy: reducing supply, reducing harm and reducing demand. The Review concerns only reducing demand, and specifically alcohol and other drug (AOD) treatment and was commissioned by the Department of Health. It sought to deliver a shared understanding of current AOD treatment funding, a set of planned and coordinated funding processes and documentation to assist future Commonwealth funding processes to respond to the needs of individuals, families and their communities. The program of research undertaken for the Review drew from comprehensive analyses of population and service provision statistics; an extensive series of key informant interviews across Australia to gather policy, research and practice knowledge; comprehensive literature reviews; case examples relevant to particular issues; liaison, discussion, and internal review and analysis. The work was undertaken between July 2013 and June 2014. A separate review was undertaken for the Aboriginal and Torres Strait Islander AOD treatment services (see section 1.4 below).

LEARNING	IMPLICATION
The report suggests that investment in AOD treatment is cost effective for the government, as for every $1 invested in AOD treatment society gains $7. AOD treatment has also been shown to: • Reduce consumption of alcohol and other drugs • Improve health status • Reduce criminal behaviour • Improve psychological wellbeing	We will need to ensure we include all of these factors in this study to explore the impact of the CDC support services in each of these areas.

LEARNING	IMPLICATION
• Improve participation in the community	
The Review notes that holistic care and the broader wraparound services (such as accommodation, general medical care and community health services etc.) provided in association with AOD treatment require consideration. The Review acknowledges that drawing lines creates an artificial boundary around AOD treatment services that does not exist in practice, however it was important for the Review to stick within the scope set out at the beginning of the process.	It will be important to consider what is in and out of scope for the funding in question and have this clear in the minds of interviewers during this consultation process.
It is pointed out that both government and non-government organisations provide AOD treatment.	It will be important for us to consider what other AOD services are being provided in the area outside of those being funded by the specific scheme in question.
Planning needs to acknowledge and accommodate that people legitimately try different modalities of treatment, often provided in different service sectors; and potentially combine those different modalities to create something that works for them.	We should aim to gather information on the different combinations of treatment that are being used within the communities as this should add an important layer to the consultation in terms of what services need to be offered.
The Review suggests that there are readily identifiable gaps in relation to AOD services being provided, particularly with regards to alcohol services. The report suggests that there is a greater demand for these services than supply.	It will be interesting to investigate whether this gap is still prevalent and the degree of the gap within each of the regions.

1.4 Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions

The Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions was written by The National Drug Research Institute at Curtin University in 2014. The Harnessing Good Intentions Review was conducted as part of a wider review of alcohol and other drug prevention and treatment services (see section 1.3 above). Using a largely qualitative approach, it was designed to provide a report from stakeholders across the Aboriginal and Torres Strait Islander community covering the following areas:

- Identification of gaps in current service provision
- Areas of unmet need
- Priority groups
- Service planning processes
- Funding models/funding arrangements and contracting issues
- Strengths, weaknesses and challenges across these areas.

LEARNING	IMPLICATION
The Review notes that substance use disorders are chronic conditions usually embedded in a web of other health and social problems and it is for this reason that treatment strategies should: • Be broader than clinical responses • Include the provision of social support services • Focus on long-term provision of services in a seamless manner	It will be important to include these broader services within the consultation where possible to get a sense of the "full picture".
Gaps in AOD treatment service provision were identified in the Review as including: • Gaps in access to a full range of services in some regions • Limited access to culturally safe or secure services • A shortage of gender-specific services and services for families and young people • A lack of on-going support and relapse prevention services for those completing intensive treatment	As the Review was written several years ago and pertains to the nation as a whole, it will be useful to investigate these gaps further as part of this consultation and see which (if any) are still prevailing today within the regions in question.
It was noted that service provision within the AOD space is often fragmented and not well coordinated, resulting in less than optimal effectiveness.	This consultation should look into how services are coordinated within each of the regions and if any learnings can be administered across the regions.
According to the report, culturally safe or secure treatment results in better outcomes, with the most effective way of ensuring treatment is being culturally secure through Aboriginal and Torres Strait Islander control of services.	It will be important to keep this in mind while conducting the consultation within the CDC trial sites.
The report noted that stakeholders generally felt that governments had a poor understanding of service gaps and priority areas, that there was a lack of consultation and involvement in decision making processes, that governments tended to have a narrow definition of 'treatment' and, there was a lack of flexibility in allocation of resources.	We will need to ensure that our consultation is inclusive of stakeholders across the board and that we consider these points made during both the design phase of the consultation and the reporting of our findings.
Across Australia, Aboriginal and Torres Strait Islander peoples have established and selected their own preferred service providers. They are well-established, have no 'competitors' and have had historically-based funding agreements. In these circumstances there is no advantage in competitive tendering and these organisations are best funded by means of individually negotiated agreements.	It will be important for us to investigate if any of these established services exist within the CDC sites and the impact they have on the communities.

1.5 A study of patient pathways in alcohol and other drug treatment

The rationale for the Patient Pathways study was based on the recognition that clients present with complex life problems as well as their alcohol and/or drug dependence and are often engaged in a diverse range of professional supports and services. The overarching aim of the 'Patient Pathways' project was to examine treatment outcomes as they relate to trajectories of clients as they move through the AOD system, their intersection between AOD services and other health and welfare services and the resulting demand on acute services. The research aimed to examine how and when service integration occurs, identify pertinent gaps between services, and outline optimal patient pathways in relation to multiple treatment goals and desired outcomes (e.g. abstinence, reduced problem severity, quality of life and treatment satisfaction) and the extent to which these vary according to patient population (i.e. primary drug of concern, severity and client complexity). It utilised a multi-mode methodology and was initially written in 2014, with an additionally supplementary paper being published in 2017.

LEARNING	IMPLICATION
The report recommended that consideration be made to structural changes to service delivery, in order to enhance treatment completion and address barriers to help-seeking – such as offering services outside of business hours, providing telephone support etc.	When speaking with stakeholders we will need to discuss whether any of these methods are currently in place and which could be introduced with the assistance of funding.
Funding models should accommodate and promote treatment journeys that involve multiple treatment modalities and greater linkage to follow-up care.	It will be important to investigate the degree to which services are catering to treatment journeys and the opportunities to increase this in the future.
The report notes that evidence from both the client survey and linkage data suggested that better outcomes are achieved among those receiving long-term residential care, it is crucial that funders and specialist service providers recognise the critical role that rehabilitation services play in a comprehensive specialist treatment system, particularly for individuals who have greater levels of complexity.	The consultation will need to look into what residential care facilities are available within the region and the degree to which this finding holds true within the CDC sites.
Another recommendation in the report is that specialist AOD services should develop and promote interventions and pathways to aftercare such as supportive community groups, including but not restricted to mutual aid groups. This could include assertive linkage to peer support groups, such as 12-step and SMART Recovery, using readily available and evidenced-based models that improve engagement with mutual aid. Being free and widely available (including online meetings), such support groups can be cost-effective models of aftercare, at least for some clients.	It will be interesting for the consultation to gauge the degree to which these services are currently being utilised and whether stakeholders feel that there is a place for this within the CDC sites.

1.6 National Ice Action Strategy

In April 2015, the Commonwealth Government established a National Ice Taskforce to report on actions needed to address increasing methenamine use in Australia. The Taskforce found that methenamine presents a unique challenge for Australia.

The goal of the National Ice Action Strategy is to reduce the prevalence of methenamine use and resulting harms across the Australian community. This Strategy includes achievable actions across a range of areas designed to help governments, service providers and communities to work together to reduce the supply and use of methenamine in Australia, and the harm it causes to the community.

LEARNING	IMPLICATION
Methenamine is also commonly used in combination with alcohol and other illicit drugs like cannabis.	It will be important to gain an understanding of the common combinations of alcohol and other drugs within each of the CDC communities, as this will assist with determining the best combination of support services for each region.
The withdrawal, treatment and recovery period for dependent methenamine use is prolonged and clinically different from other drugs. However, similar to other illicit drug users, many dependent methenamine users also have co-occurring mental health issues, or multiple drug misuse issues, that further complicate treatment.	This finding in the report further highlights the need to investigate the range of holistic support services that may be desired and needed within each of the regions.
There is an average time-lag of around 5 years between first problematic use and when people seek help for meth. Many users only seek help once they have developed a long-term or severe dependence.	We will need to discuss with stakeholders their views on this finding within each of the CDC regions and look into what early intervention services are currently being provided and could potentially be expanded.
Many services are able to treat people with alcohol, cannabis and heroin dependency.Methenamine users have different treatment needs and some services may not yet be configured to provide effective treatment.	It will be important during the consultation to gauge the extent of the methenamine issue within the CDC regions and whether there are current services within said regions able to handle this particular type of drug treatment.
Law enforcement will remain critical in helping to stop the supply of meth.	We should consider including local law enforcement in our consultation.

1.7 Final report of the National Ice Taskforce

The National Ice Taskforce was established on 8 April 2015 to advise the Government on the development of a National Ice Action Strategy. The final report of the National Ice Taskforce that was published in 2015 focuses on the drug methenamine and how Australia might best approach the problem of methenamine use within the context of the National Drug Strategy (NDS). The report drew extensively on the findings of the 2013 National Drug Strategy Household Survey (NDSHS), run by the Australian Institute of Health and Welfare.

LEARNING	IMPLICATION
The report notes that Australia's treatment and support system at the time was not particularly well designed to respond to methenamine use. Many services are designed for other types of drugs—for example, some detoxification services don't cater well for the comedown associated with stimulants, and some services lack appropriate follow-up for the extended withdrawal period associated with meth.	As noted above, it will be important during the consultation to gauge the extent of the methenamine issue within the CDC regions and whether there are current services within said regions able to handle this particular type of drug treatment.
It was recommended that the Commonwealth, state and territory governments should work together to improve coordination between community-based alcohol and other drug services, and support referral pathways between local health, support, employment and other programmes. This should build on existing coordination and governance mechanisms where possible, and involve Commonwealth, state and not-for-profit services to establish cross-service networks and provide better support for people seeking help for alcohol and other drug problems.	It will be important to include stakeholders from state and territory governments and the not-for-profit sector within our consultation.
Disadvantaged populations are at greater risk of harm from illicit drugs. The Taskforce received a number of submissions that identified the need to consider the broader social determinants that contribute to drug use, including the complex issues of social and economic exclusion, poverty, marginalisation, racism and stigmatisation.	It will be vital to ensure the consultation considers the differing broader social determinants present in each of the CDC regions.

1.8 National drug strategy 2017-2026

Since its first iteration in 1985, Australia's National Drug Strategy has been underpinned by an objective of minimising the harms associated with alcohol, tobacco, illicit drug and pharmaceutical drug use. Published in 2017 the National Drug Strategy 2017-2026 was designed to provide a national framework which identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments in partnership with service providers and the community, and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies.

LEARNING	IMPLICATION
Alcohol, tobacco and other drug problems also co-occur with social, economic and health determinants, such as discrimination, unemployment, homelessness, poverty and family breakdown.	While we need to ensure that we are not going outside of the scope of this consultation it will be important to gather evidence around the entire situation in each of the CDC communities in order to appropriately reach the consultation objectives.
Drug use occurs across a continuum, from occasional use to dependent use. Delaying first use can also lead to improved health and social outcomes. The earlier a person commences use, the greater their risk of harm. This includes mental and physical health problems and a greater risk of continued drug use. Strategies that delay the onset of use prevent longer term harms and costs to the community.	Each CDC region is likely to have a differing proportion of people at different stages of the continuum, gaining an understanding of this from stakeholders will help to assess how funds should be split across different services.
The best course of action is determined on the nature, complexity and severity of problems. It is critical, therefore, to ensure a range of services and agencies that are appropriately connected through established referral pathways.	This highlights the need for this consultation to help assess the range of services required within each of the CDC sites.
The strong partnership between health and law enforcement has been a key strength of Australia's National Drug Strategy and is central to the harm minimisation approach. However, in recognition of the social determinants of alcohol, tobacco and other drug problems and that the age and stage of life issues associated with substance use can result in different risks and harms require integrated, holistic and systems-based partnerships. This includes partnerships between both government and non-government agencies in areas such as education, treatment and services, primary health care, justice, child protection, social welfare, fiscal policy, trade, consumer policy, road safety and employment. It also includes partnerships with researchers, families and communities, peer educators, drug user organisations, Aboriginal and Torres Strait Islander communities, and other priority populations.	This highlights the importance for partnerships and including various stakeholders from a number of backgrounds throughout the consultation.
It is critical to ensure that any efforts to reduce the disproportionate harms experienced by Aboriginal and Torres Strait Islander peoples are culturally responsive and appropriately reflect the broader social, cultural and emotional wellbeing needs of Aboriginal and Torres Strait Islander peoples. Planning and delivery	This further highlights that our approach of interviews with Indigenous community leaders, service providers and stakeholder representatives being conducted one-on-one by CIRCA's local Aboriginal Consultants,

LEARNING	IMPLICATION
of services should have strong community engagement including joint planning and evaluation of prevention programs and services provided to Aboriginal and Torres Strait Islander communities taking place at the regional level.	(in-person if COVID-19 restrictions allow) will help to guarantee the highest level of cultural safety to consultation participants. In-person consultations, conducted by Aboriginal people, allows our consultants and consultation participants the ability to converse with one another easily and freely.

CONSULTATIONS TO INFORM FUNDING TO ALCOHOL AND OTHER DRUG TREATMENT SERVICES

Recruitment Specifications & Screener

Recruitment Specifications:

11 interviews will be conducted in each of the four community sites. Interviews will be held face-to-face, online or over the phone (depending on cohort and COVID restrictions) and will last approximately 60 minutes each. In each community, interviews will be conducted with:

1. 2x interviews with representatives at **local Aboriginal Community Controlled Health Organisations (ACCHOs)**
2. 2x interviews with **local mainstream health service providers**
3. 2x interviews with **local Alcohol and Other Drug (AOD) service providers**
4. 5x interviews with **Aboriginal local experts and Aboriginal community leaders**

Incentives $80 per participant, paid via cash after participants have signed the Consent Form.

	Goldfields WA	Ceduna SA	Bundaberg-Hervey Bay QLD	East Kimberley WA	Total
Representatives at ACCHOs	2	2	2	2	8
Mainstream health service providers	2	2	2	2	8
AOD service providers	2	2	2	2	8
Local Aboriginal community leaders	5	5	5	5	20
TOTAL INTERVIEWS	**11**	**11**	**11**	**11**	**44**

Within each group:

- All participants will be people who identify as one of the cohorts identified above.
- All participants should be aged over 18 years
- All participants should live or work in the community identified above
- All participants should be knowledgeable about the local drug and alcohol context

Exclusions (Please exclude the following people):

- People who do not identify as any of the cohorts
- People under the age of 18

Recruitment Screener

Good morning / afternoon / evening. My name is **[FULL NAME]** from CIRCA, which stands for the Cultural and Indigenous Research Centre Australia. May I please speak with…?

CONTINUE: I'm calling to invite you to participate in some consultation with CIRCA, an independent research company, on behalf of the Department of Health. They are conducting consultation with people from a range of different backgrounds, to better understand the drug and alcohol treatment needs of your community, if there are any gaps in treatment services, and how to fill these gaps. Consultation in the four trial sites will continue till the end of November with a final report due back to the Department of Health by early January 2022. It is expected that the grants process to administer the funding will begin in early 2022 which will be informed by the findings of the report. We are not selling anything – this is genuine community consultation to explore your views, opinions, and experiences.

We're looking to run eleven interviews with people working in health and drug and alcohol services, as well as Aboriginal local experts and Aboriginal community leaders, to explore their expertise, opinions, and experiences. The interview will last around 60 minutes. These discussions are relaxed and informal, and most people enjoy the experience. The interview will be run either face-to-face, online or over the phone. If participating in-person, we ask that participants take precautions against COVID by physical distancing, using hand sanitiser before and after the interview, [if catering is provided] not to share food, and not attend the interview if you have COVID symptoms. You may choose to wear a face mask. These precautions against COVID may be adjusted depending on your State's rules.

Once you've completed the interview, you will receive $80 cash-in-hand as a thank you for your time.

Would you be interested in participating?

IF YES, CONTINUE: I just need to ask a few questions to check that you qualify to participate, and because we want to ensure we have a good cross-section of people taking part in the discussions.

Shall we go ahead?

IF YES, CONTINUE:

1. What community/town do you live/work in? Check if in target site. **IF NOT, TERMINATE.**
2. Are you over 18?
    a. Yes
    b. No – **TERMINATE**
3. Do you identify as Aboriginal or Torres Strait Islander?
    a. Yes, Aboriginal
    b. Yes, Torres Strait Islander
    c. Yes, both Aboriginal and Torres Strait Islander
    d. No

4. Where do you work?

    a. Local Aboriginal Community Controlled Health Organisation (ACCHO), please name: _____

    b. Local mainstream health service provider, please name: _____

    c. Local Alcohol and Other Drug (AOD) service providers, please name: _____

    d. Other

5. What is your role there?

    a. _____

6. Do you feel you have expertise or knowledge about drug and alcohol treatment needs and services in the local community?

    a. Yes

    b. No - **TERMINATE**

Closing – IF Qualified

I am happy to confirm that you have qualified to participate in this consultation. The interview will run on **[INSERT RELEVANT LOCATION, DATE AND TIME].** Will you be able to participate?

IF YES, CONTINUE:

As mentioned earlier, these discussions are relaxed and informal, and most people enjoy the experience. It will last around 60 minutes. Once you've participated in the interview, we will give you $80 as a thank you for your time.

If you need to contact me for any reason, including if you are unable to participate on the day or are running late, my number is **[SAY PHONE NUMBER]**.

I will send you an email or telephone you to re-confirm your interview closer to the date. May I have your email address, or would you prefer us to telephone you? **[COLLECT EMAIL / SUITABLE PHONE NUMBERS.]**

Just to recap, my name is **[INSERT NAME]** from CIRCA. This consultation will be carried out in compliance with the Federal Privacy Act and the information you provide will be kept completely confidential and used only for consultation purposes. Thank you for your time today and in anticipation of your participation in this important consultation study.

Closing – IF NOT Qualified

I'm very sorry, but you are not eligible to participate in this consultation. Thank you for your time. Have a nice day.

Appendix E Stakeholder discussion guide

PROJECT NAME:	**Consultation to Inform Funding for Alcohol and Other Drug Treatment Services to Support CDC Trial Participants**
CLIENT:	**Department of Health**
JOB NUMBER:	**211682**
DATE:	**12th OCTOBER 2021**

This discussion guide has been designed for the interviews with representatives from the following sources:

- Commonwealth Department of Health
- Commonwealth funding bodies
- State Health Department
- Primary Health Networks
- ANACAD & other drug peak network representatives

Note: These interviews are with the named contacts provided by the Department of Health as well as other relevant contacts as identified during the interviewing process.

Overview of session flow:

SECTION:	AIM:	TIMING:
1. **INTRODUCTION**	• To engage the participant, build rapport and inform them about the consultation process and purpose, learn a bit about their role and responsibilities	**2-5 mins**
2. **CONSULTATION OBJECTIVES**	• Explore key focus areas for the consultation and identify additional stakeholders for the consultation	**5-10 mins**
3. **CURRENT SERVICE PROVISION**	• Identify what is working well in drug treatment, or less well at the CDC sites and more broadly across Australia, plus service mapping information	**5-10 mins**
4. **DRIVERS AND BARRIERS**	• Explore the drivers and barriers to the uptake of treatment services	**5-10 mins**
5. **GAPS AND PRIORITIES**	• Identify specific gaps in treatment that need to be addressed, and local priorities	**5-10 mins**
6. **GRANT FUNDING**	• (Where appropriate) explore what's currently working well in the grant funding process and anything that this round of funding can learn from previous experience	**5-10 mins**
7. **FINAL COMMENTS, THANK AND CLOSE**	• Thank the participant and round off the discussion	**2-5 mins**
	TOTAL:	**UP TO 60 mins**

SECTION 1: INTRODUCTION 2-5 MINS

Aim: To engage the participant, build rapport and inform them about the consultation process and purpose, learn a bit about their role and responsibilities

INTERVIEWER TO INTRODUCE PURPOSE OF THE SESSION:

- Thank you for agreeing to take part in this study.
- All reporting to be anonymised and reported at aggregate level. Transcripts of interviews will be de-identified before sharing.
- We will be chatting for about 50 minutes today
- We would also like to reassure you that: We will comply with all Australian laws protecting your personal data and follow the Market and Social Research (M&SR) Privacy Code.
- We are recording, which will only be reviewed for internal analysis.
- Obtain consent.
- Any questions?

PRIVACY INFORMATION IF REQUIRED:

- *Fiftyfive5 is an independent research agency that has been engaged by a client to conduct this research on its behalf.*
- *The information collected during this consultation may be used to inform Funding for Alcohol and Other Drug Treatment Services to Support CDC Trial Participants and consent to it being recorded (including by audio, video, photos, transcription) for use and viewing by the commissioned social and market research agency.*
- *The de-identified information will be provided to the Commonwealth government and consultation contractors, and may be shared with program partners in state, territory and New Zealand governments, and it may be aggregated for inclusion in public reports and other materials.*
- *Each participant to this study may contact a FiftyFive5 staff member to amend, view or delete any information collected during this consultation.*

INTRODUCTION:

Before we get into the main discussion it would be great to learn a little more about your role and the work you do on Alcohol and Other Drug treatment services. Can you please tell me about that?

- Does your work include the Cashless Debit Card (CDC) trial site areas?
- What aspects of alcohol and other drug treatment does your work involve?

SECTION 2: CONSULTATION OBJECTIVES 5-10 MINS

Aim: Explore key focus areas for the consultation and identify additional stakeholders for the consultation

We have been commissioned to undertake consultation to inform expenditure to establish new and support existing alcohol and other drug treatment services for each of the four existing Cashless Debit Card (CDC) trial sites. The consultation will deliver the following:

- Ensure that the new funding builds on and complements existing alcohol and other drug treatment services and maximises efficiency and effectiveness of service delivery
- Provide advice on the alcohol and other drug treatment needs of the four communities;
- Identify gaps in treatment services and the most effective and efficient method to fill those gaps; and
- Inform a grant process to deliver funding for new and existing treatment services in each location as required.

- I've got a few questions to ensure that I build on your knowledge and understanding of these areas, but do you have any initial comments in response to these areas of focus?
- Who would you recommend that we engage with in the four CDC trial sites, or beyond, that could contribute their understanding of these issues to the consultation?

SECTION 3: CURRENT SERVICE PROVISION	5-10 MINS

Aim: Identify what is working well in drug treatment, or less well at the CDC sites and more broadly across Australia, plus service mapping information

I'd like to spend a little time now talking about drug treatment service provision…

- How would you describe the provision of drug treatment at the trial sites/ in x state/nationally (probe as appropriate with stakeholder)?
- What does current provision of treatment services focus on? (probe as appropriate trial sites/ in x state/nationally)
- What has encouraged this focus?
- To what extent is the current provision leading to positive outcomes?
- How might this be enhanced?
    - Is there anyone we should speak to in the course of this consultation (at x trial site/State health level) that would be able to further develop our understanding of these points?
    - If appropriate – would you be able to share any mapping of state-funded/CDC trial site funded Alcohol and other drug treatment services (note we already have a list of Commonwealth and NIAA funded services)

SECTION 4: DRIVERS AND BARRIERS	5-10 MINS

Aim: Explore the drivers and barriers to the uptake of treatment services

Now I'd like to speak about what shapes individuals' uptake of services…

- In general, what stops someone from seeking treatment in Australia, x state, at x trial site?
- Why does this happen?
- Does this differ by specific groups of people – AoD user type/cultural groups/age groups/gender
- How is this shaped by availability of qualified personnel?
- What would help mitigate this from happening?
- *Probe* – holistic approach to treatment – reflecting on multiple factors that shape health outcomes
- Probe - cultural safety and appropriateness of services and the impact of this

And conversely, what encourages someone to seek treatment in Australia, x state, at x trial site?

- Why does this happen?
- Does this differ by specific groups of people – AoD user type/cultural groups/age groups/gender
- What can we learn from this for the design of treatment services?

SECTION 5: GAPS AND PRIORITIES	5-10 MINS

Aim: Identify specific gaps in treatment that need to be addressed, and local priorities

So focusing more on the gaps in the provision of treatment services…

- Where are the gaps in the provision of treatment in Australia, x state, at x trial site?
- What are the implications of these gaps for treatment of individuals across Australia, x state, at x trial site?
- What should be the priority order for addressing these gaps?
- Where would funding for services have the most positive impact on outcomes?
- Where would it be of benefit for funding to be scaled up or down, as opposed to funding new services?

SECTION 6: GRANT FUNDING	5-10 MINS

Aim: (Where appropriate) explore what's currently working well in the grant funding process and anything that this round of funding can learn from previous experience

So thinking more about the process that guides grant funding…

- How would you characterise the process of making decisions in grant funding for AOD treatment in Australia, x state, at x trial site?
- What are the implications of these processes?
- How might it be improved?
- What should be retained for the grant funding that will take place for AOD treatment services across the four CDC trial sites?

SECTION 7: FINAL COMMENTS, THANK AND CLOSE	2-5 MINS

Aim: Thank the participant and round off the discussion

- Do you have any further comments to make on the topic at a CDC site level or more broadly?
- Thanks so much for your time, it has been greatly appreciated!

Appendix F Community discussion guide

The Study

The Cultural and Indigenous Research Centre Australia (CIRCA) and Fiftyfive5 have been contracted by the Department of Health to consult with key informants, local health service providers, and Aboriginal experts and community leaders. These consultations aim to understand how funding to alcohol and other drug treatment services can be managed to best support all people in Cashless Debit Card (CDC) Trial communities.

The information collected in these interviews will be used to provide the Department of Health and other partners with a picture of the current services available, gaps, and context in each community. It will also inform recommendations for treatment services and ways that they can be better implemented to cater for the unique needs of each community. Consultation in the four trial sites will continue till the end of November with a final report due back to the Department of Health by early January 2022. It is expected that the grants process to administer the funding will begin in early 2022 which will be informed by the findings of the report.

Your Participation

Participation in the interview is voluntary and you can choose not to participate in all or part of the interview. You can also choose to withdraw your participation at any time.

If you don't want to or can't answer any question, we will move on to another question. All comments are welcome – there are no right or wrong answers.

Confidentiality

Your personal information will remain confidential. Anything you say in this interview will not be linked directly to you and all of your comments will remain anonymous. Only the CIRCA consultation team will have access to this information.

Audio recording

To ensure that we capture all the points that you raise, we would like to audio-record the discussion. However, our discussion will be kept confidential. The recording will be transferred on to CIRCA's computers but will be destroyed once we have made notes and completed an issues-based report. I will ask you in a moment if you consent to recording this conversation.

Avenue for addressing concerns

If you have any concerns about the consultation, please raise them with any member of the CIRCA consultation team in the first instance, and we will be happy to try and address them for you. We can be reached on (02) 8585 1353 or via e-mail: info@CIRCAresearch.com.au

In case of any serious concerns, please contact Lena Etuk, Research & Evaluation Manager at CIRCA: (02) 8585 1330, lena@CIRCAresearch.com.au

Questions

Do you have any questions about this interview? *(If Yes, answer questions)*

Record consent

Do you agree to do this interview? Yes/No

If yes, have participant(s) sign the consent form. If no, ask participant(s) to leave the interview.

Are you happy for the interview to be audio-recorded? Yes/No If no, I will take notes.

If yes, start recording

If no, stop recording and take notes instead

Field researcher to check:

☐ Participants have been read the consent form and consent of each participant has been recorded

☐ Participants each have a copy of the Participant Information Sheet

☐ Participants have received their incentive

Key Informant Discussion Guide

Opener and introductions

OBJECTIVE: Get to know participants a bit and give them a chance to get to know the interviewer a bit. Build rapport.

1. Tell participants a little bit about yourself - where you're from, your mob, how you've come to be involved in the consultations, and anything else.
2. Ask the participants about themselves
3. Can you tell me a bit about the work you do, and your role?

AOD service needs of the community

OBJECTIVE: Understand the context of the community, including social and health issues and existing services.

4. What would you say are the main health or social issues in this community?
    i. PROMPT: Are there issues in the community with alcohol and drug use?
5. What kinds of services exist in the community to support these issues and the people facing them?
    i. PROMPT: Drug and alcohol services, in-patient treatment facilities, men's treatment services.

Successes and challenges in past and existing AOD approaches

OBJECTIVE: Understand what has worked and what hasn't in past AOD approaches, the evidence for this, and what can be applied to future learnings.

6. What are some successes you've observed in the past and with current alcohol and drug treatment approaches in this community? How about challenges in this space?
    i. PROBE: [For successes] do you have any evidence on the effectiveness of these approaches?
7. Are there learnings from this that can be applied to future approaches?

Gaps in services

OBJECTIVE: To understand the gaps in AOD service delivery in the community, and ways that these gaps could be filled

8. Are there any major gaps in alcohol and drug treatment services in your community?
    i. PROMPT: Drug and alcohol services, in-patient treatment facilities, men's treatment services.
    ii. PROMPT: What about any gaps in post-treatment services or prevention services?
9. How do you think these gaps could best be filled? What kinds of things are needed in this community to help with this?
    i. PROBE: Do you have any evidence that these things would work?
10. Are there other services that fill these gaps? What kinds of services, and how do they fill the gap?
    i. Are there any examples of interagency cooperation to deliver services, or partnerships between services?
11. Apart from alcohol and drug treatment services, what are the other ways that people with AOD challenges/issues are supported in treatment and planning for treatment in the community?
    i. PROMPT: What is the role of family, community, Aboriginal organisations, etc.
    ii. PROBE: Do you have any suggestions on how these supports could be strengthened?

Cultural safety and appropriateness

OBJECTIVE: Explore perceptions of cultural safety of services, and the features of what makes a service culturally safe.

12. In what ways do you feel the alcohol and drug services in this community demonstrate sensitivity, empathy, and respect to the cultural identity of the Aboriginal and Torres Strait Islander peoples who seek them?
    i. How could they be improved?
    ii. PROMPT: What things are needed to make an AOD service culturally safe and appropriate?

Scaling existing treatment services

OBJECTIVE: Explore the ability to and appropriateness of scaling existing treatment services in the community

13. How capable do you think this community is to scale the existing treatment services here? Would this be appropriate?
    i. PROMPT: Why/why not?

Mobility of community members and services

OBJECTIVE: Understand the geographical footprint of the services in the community, and where community members may go outside the community to access treatment or services

14. Are there other areas or communities that people from here go to receive AOD treatment or services? Where?

15. Are there any other communities that the local Aboriginal people here commonly have community, family, or cultural ties to?

16. What is the geographical area that the local AOD services cover?

    i. Is outreach a part of their delivery model? And if so, is this delivered effectively?

    ii. How frequently do they visit remote communities to deliver services?

Community readiness

OBJECTIVE: Explore the readiness of the community to support AOD services, in terms of workforce and attitude

17. How is this community placed to support alcohol and other drug treatment services?

    Probe, if necessary:

    i. Is there enough workforce capacity to sustain these services?

    ii. What are the community attitudes to alcohol and drug services? Is there any resistance?

Grant funding mechanisms

OBJECTIVE: Understand what's worked and what hasn't in past grant funding mechanisms, and any potential issues with implementing a grant program to fund new and existing treatment services in these communities

18. What are some successes you've observed in the past and with current grant funding in this community? How about challenges in this space?

    i. PROMPT: How about in the AOD space?

19. Are there learnings from this that can be applied to future grant funding mechanisms?

20. Do you see any issues that could come up from implementing a grant program to fund new and existing treatment services here?

    i. If so, what kinds of things could be put in place to avoid these issues, or make the program more successful?

Thank you for your time.