**NORTHERN TERRITORY DEPARTMENT OF HEALTH AND
COMMUNITY SERVICES**

Alcohol and Other Drug Program
Profile of Services and Interventions
Project

Workshop Paper

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Background

The current document is a companion to the earlier background paper circulated to those invited to participate in workshops to assist in further development of the Profile of Alcohol and Other Drug Services in the Northern Territory.

1.1 PURPOSE OF THIS DOCUMENT

The current document is designed to provide the basis for a workshop to be held in each of Alice Springs (18th May) and Darwin (19th May) and outlines a series of options related to:

- needs and priorities for alcohol and other drug related intervention services in each of the five regions;
- development of performance indicators for each service type; and
- approaches to facilitating establishment of and compliance with best practice standards.

It is anticipated that the workshops will consider the options, refine some, perhaps reject other and potentially identify alternatives to assist in development of recommendations for the final report from the project.

1.2 WORKSHOP FORMAT

HMA views the workshops as an opportunity to test our ideas and gain further advice from participants so that the final recommendations of the final report are viewed as appropriate and enjoy broad support within the alcohol and other drugs sector in the Northern Territory.

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Options for priorities in each region

This chapter outlines options for service development priorities to address the needs and gaps in each of the five regions in the Northern Territory. The data collected in the course of the project was presented in the background paper circulated last week, and this has provided the basis for the needs and gaps identified in the current document.

2.1 GREATER DARWIN REGION

The needs identified within the Darwin region were:

* services appropriate to women, and particularly women with children;
* increased access to aftercare services, including half-way houses or supported accommodation;
* systems for supporting aftercare for clients residing outside the Darwin metropolitan area;
* potential need for expanded detoxification services;
* a system of services for young people;
* clarification of service access for clients on community supervision orders;
* expansion of community based services in remote communities.

We are seeking input from participants regarding:

* the validity of each of these issues as key needs or gaps within the region;
* any needs or gaps that may have been overlooked; and
* the relative priority for addressed these needs.

2.2 EAST ARNHEM REGION

The needs identified in the East Arnhem region were:

* sobering up facilities in Nhulunbuy;
* support for communities and families to respond to alcohol and violence; and
* development of local residential rehabilitation options;
* expansion of counselling capacity.

Again, we are seeking input from participants regarding:

* the validity of each of these issues as key needs or gaps within the region;
* any needs or gaps that may have been overlooked; and
* the relative priority for addressed these needs.

2.3 KATHERINE REGION

The needs identified in the Katherine Region were:
* support for remote communities to respond to alcohol and other drug issues;
* consistently available counselling services in Katherine; and
* a drop in or support centre for visitors to Katherine from remote communities.

Again, we are seeking input from participants regarding:

- the validity of each of these issues as key needs or gaps within the region;
- any needs or gaps that may have been overlooked; and
- the relative priority for addressed these needs.

2.4   TENNANT CREEK REGION

The needs identified in the Katherine Region were:

- access to post treatment options such as employment and training; and
- case management services for families experiencing multiple areas of difficulty, including alcohol and other drug use.

Again, we are seeking input from participants regarding:

- the validity of each of these issues as key needs or gaps within the region;
- any needs or gaps that may have been overlooked; and
- the relative priority for addressed these needs.

2.5   ALICE SPRINGS REGION

The needs or gaps identified in Alice Springs were:

- an appropriate and accepted service model to support remote communities within the region to respond to alcohol and other drug related problems;
- provision of mainstream services in a form that is accessible and appropriate to Aboriginal people;
- development of effective responses to inhalant use within Alice Springs;
- improved linkages between primary health care, alcohol and other drug services and other organisations to enhance aftercare, relapse prevention and follow-up; and
- improved interaction between ADSCA and mental health services in managing people with borderline personalities.

Again, we are seeking input from participants regarding:

- the validity of each of these issues as key needs or gaps within the region;
- any needs or gaps that may have been overlooked; and
- the relative priority for addressed these needs.

2.6   SYSTEMIC PRIORITIES

Moving the focus from individual regions or services, it appeared there were a number of needs or gaps across the Northern Territory as a whole. These were:

- an apparent decline in the number of clients entering treatment or being reported into the NMDS (2,557 episodes in 2001-02; 2,225 episodes in 2002-03; and 1,865 episodes in 2003-04) despite hospital and corrections data suggesting need for services may be increasing;

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- collaboration between the Northern Territory and Commonwealth in development of regional services or systems to support remote communities to respond to alcohol and other drug problems;
- expansion in services for women;
- increased access to appropriate services for remote communities
- increased skills base within the AOD sector;
- improved response to AOD in primary care settings; and
- increased alignment of interventions available with current evidence.

Advice from stakeholders in workshops regarding broader systemic priorities will be eagerly received.

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Options for achieving best practice standards

This section presents three options for the implementation of best practice standards for alcohol and other drug agencies in the Northern Territory.

3.1 REQUIREMENT FOR EXTERNAL ACCREDITATION

One approach to requiring services to achieve standards of practice is to require all agencies to achieve accreditation with an external body, in a manner comparable to hospital accreditation through the Australian Council on Healthcare Standards. Quality Management Services, formerly CHASP, has developed standards for alcohol and other drug services and provides an accreditation service. This approach would require:

(1) Agreement on the specific standards to be applied and against which accreditation would be granted.
(2) Introduction of a requirement, potentially within funding agreements, that services must achieve accreditation by a given date, say 3 to four years after introduction.
(3) Identification of resources to offset the cost of accreditation process.
(4) Allocation of resources to support agencies to develop the policy and procedures documentation required for accreditation.
(5) Allocation of resources to allow agencies to comply with physical, staffing and operational requirements of accreditation.

Strengths	Weaknesses
• Provides a structure, independent approach to assessing the standard of operation of individual agencies;	• Represents a significant additional cost to services to pay for external review and accreditation;
• Limits concerns regarding potential conflicts of interest in assessing the standard of service provided by individual service or agencies;	• May result in significant costs to the Department to allow agencies to undergo accreditation and achieve the required standards;
• Involves an approach that is consistent with other sectors of the health system;	• Capacity of external reviewers to fully appreciate the operating environment of agencies in the Northern Territory;
• Facilitates establishment of a baseline from which each service can progress; and	• Limited control within the Northern Territory regarding the development and application of standards; and
• Ensures that all agencies services are assessed objectively and consistently.	• Ongoing cost and requirement of maintaining accreditation.

3.2 INCLUSION OF BEST PRACTICE STANDARDS IN FUNDING AGREEMENTS

An alternative to establishing an external accreditation process is for funding agreements to include specific standards, and indicators for achievement by agencies. The work of Dale and Marsh (2004) (copy attached) provides a range of standards and indicators drawn from the current evidence base that could be applied. This would require a number of steps to be taken by the Department, namely:

(1) Agree and promulgate a range of standards and indicators for all agencies, and for specific types of services.
(2) Incorporate negotiation of standards to be achieved each year (and subsequently maintained with each funded agency or service.
(3) Establish a process for validating achievement and maintenance of standards with funded agencies and services.
(4) Establish a time line for achievement of an agreed minimum set of standards by all agencies/services.

Strengths	Weaknesses
• Allows standards to be implemented iteratively;	• Requires more complex negotiations between the department and individual agencies;
• Engages the Department and individual services in negotiation of specific standards to be applied;	• The negotiation and monitoring process may have resource implications for both agencies and agencies;
• Allows the pace of implementation to respond to the current position of each agency in relation to the proposed standards and resources available for their achievement;	• Variation between agencies and the requirements within their funding agreements may contribute to perceived favouritism toward some agencies;
• Links achievement of standards to funding; and	• The Department may be viewed as experiencing a conflict of interest, particularly toward internal services and where achievement of standards may have resource implications for the Department; and
• Ensures regular review of progress to achieving standards.	• The extent to which standards and funding agreements can be enforced will ultimately be determined at the political level where non-government organisations are involved.

3.3 ESTABLISHMENT OF A SELF RUGLATING FRAMEWORK

An alternative to the Department establishing and implementing a standards framework would be for agencies to agree to a code of conduct which incorporates a range of standards drawn from the current evidence base (again Dale and Marsh (2004) provides a framework), and commit to compliance. Effectively this approach would place the onus for compliance on agencies and limit audit to cases where there was concern regarding failure to comply. This approach would require:

(1) Agencies to collectively agree on a code of conduct.
(2) The Department to accept that the code of conduct agreed by agencies was adequate and appropriate.
(3) Inclusion of compliance with the code of practice within funding agreements.
(4) Establishment of a process for auditing agencies should concern be raised regarding compliance with the code of conduct.

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Strengths	Weaknesses
• Provides a flexible approach to implementing standards that allows agencies' priorities to be reflected;	• Requires development of a forum in which agencies can agree a code of conduct that is accepted by the Department;
• Minimises the costs involved in implementation of standards;	• Allows idiosyncratic interpretation and application of the agreed code of conduct;
• Reduces the need for continual review and monitoring of standards;	• Establishing a case for auditing a service where concerns have arisen may be difficult;
• Provides a basis for reviewing agencies where concerns have been raised regarding the standard of services provided;	• The cost of auditing individual services when required may be significant; and
• Places responsibility with agencies for compliance.	• Responding to concerns regarding individual agencies may result in an adversarial climate developing.

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Performance indicators

HMA has been asked to suggest appropriate performance indicators for each type of service. This section provides a brief outline of the logic underpinning our development of performance indicators before proposing a limited range of key performance indicators. It is anticipated that the range of indicators will be further developed in the course of the workshops.

4.1 FRAMEWORK FOR DEVELOPING PERFORMANCE INDICATORS

Performance indicators can be considered at a number of levels within an over service system or program. The schematic outlined in Figure 1 (below) provides and outline of the framework we have used in thinking about performance indicators for alcohol and other drug services. Of particular interest are indicators related to organisational performance (assuming that the service system in each region is the organisational unit, and efficiency, cost effectiveness and quality at the individual agency or service level.

Figure 1: Schematic of the conceptual framework underlying development of performance indicators

Utilising the schematic, particularly at the agency or service level requires a clear definition underlying the program logic that guides the activities and operation of the service. That is to develop agency specific indicators will require each agency to clearly articulate the objectives of the service they provide and the specific strategies or activities to be applied in achieving these objectives. Review of current funding agreements suggests that this has been an area in which work has already been undertaken.

4.2 PERFORMACE INDICATORS FOR SERVICE TYPES

This section outlines proposed performance indicators for each service type. It is not intended to provide an exhaustive list of potential indicators, rather to suggest a limited range of key

indicators. It is hoped that workshops will allow discussion of these indicators, and potential identify alternative indicators that participants consider more important or valuable.

4.2.1 Primary health care services

Proposed alcohol and other drug performance indicators for primary health care services are:

(1) Proportion of clients asked about their alcohol and other drug consumption during initial history taking and assessment.

(2) Proportion of clients reporting consumption of alcohol or other drugs at above low risk levels provided with feedback regarding their alcohol or other drug use.

(3) Proportion of clients for whom alcohol or other drug use represents a risk successfully referred to specialist alcohol and other drug services

4.2.2 Assessment and referral services

Proposed indicators for specialist alcohol and other drug assessment services, and the assessment activities of specialist alcohol and other drug services are:

(1) Proportion of clients contacting the service who receive a comprehensive assessment.

(2) Proportion of clients assessed for whom a measure of dependence is undertaken.

(3) Proportion of clients assessed with whom a treatment/management plan is developed.

(4) Proportion of clients with low to moderate levels of dependence provided with or referred to community based counselling or brief intervention.

(5) Proportion of clients with moderate to high levels of dependence referred to or provided with appropriate treatment.

4.2.3 Sobering-up shelters

Proposed indicators for sobering up shelters are:

(1) Proportion of clients linked to other health and welfare services.

(2) Proportion of clients provided with a shower and clean clothes.

(3) Proportion of staff trained to identify ad respond to clients entering withdrawal.

4.2.4 Community based counselling services

Proposed indicators for community based counselling services are:

(1) Proportion of clients linked to other services whilst the client is engaged.

(2) Proportion of clients with whom treatment goals are developed.

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(3)   Proportion of clients achieving 50% or more of their treatment goals.

(4)   Proportion of clients with higher levels of dependence and lacking stable housing or primary relationships referred for residential rehabilitation.

(5)   Proportion of clients assessed as experiencing cognitive deficits provided with, or referred to a behaviourally based intervention.

(6)   Proportion of counselling staff receiving regular, structured clinical supervision.

4.2.5   Detoxification services

Proposed indicators for detoxification services are:

(1)   Proportion of clients assessed by detoxification services as having a history of moderate to severe withdrawal symptoms provided with residential detoxification.

(2)   Proportion of clients linked with other health and welfare services in the course of providing detoxification.

(3)   Proportion of clients followed up subsequent to detoxification.

(4)   Proportion of personnel receiving structured clinical supervision at least monthly.

4.2.6   Pharmacotherapy services

Proposed indicators for pharmacotherapy services are:

(1)   Proportion of clients entering methadone or buprenorphine maintenance remaining in treatment for two years.

(2)   Proportion of clients returning "dirty" urine samples in any three month period.

(3)   Proportion of clients commencing withdrawal regimes that complete them.

4.2.7   Community based rehabilitation programs

Proposed indicators for community based rehabilitation programs are:

(1)   Proportion of clients receiving a comprehensive assessment.

(2)   Proportion of clients engaged in living skills training (e.g. budget, cooking, and stress management.

(3)   Proportion of clients receiving advice and information regarding potential risks of alcohol or other drug use and strategies to reduce harm.

(4)   Proportion of clients receiving an assessment and engaged in a treatment plan.

(5)   Proportion of staff with formal alcohol or other drugs training.

4.2.8   Residential rehabilitation services

Proposed indicators for residential rehabilitation services are

(1)   Proportion of clients assessed that are referred to another service.

(2)   Proportion of clients for whom a treatment plan which includes education, training, employment skills and living skills are incorporated.

(3)   Proportion of clients receiving a comprehensive medical assessment and follow-up.

(4)   Proportion of clients for whom a comprehensive reintegration program is implemented at the conclusion of treatment.

(5)   Proportion of clients receiving specific training regarding relapse prevention.

(6)   Proportion of clinical personnel receiving structured clinical supervision at least once each month.

(7)   Proportion of clinical personnel with agree

4.2.9   Aftercare/follow-up programs

Proposed indicators for after care services are:

(1)   Proportion of clients followed up.

(2)   Proportion of clients linked to at least one other service.

(3)   Proportion of clients with whom follow up procedures are agreed prior to discharge.

4.2.10 All services

A number of performance indicators will be relevant to all services, and the following are proposed:

(1)   Proportion of clients referred from primary health care services.

(2)   Proportion of clients completing a comprehensive assessment.

(3)   Proportion of clients with whom a treatment plan is agreed.

(4)   Proportion of clients achieving 50% of agreed treatment goals.

(5)   Proportion of clients effectively referred to appropriate health and welfare services.

(6)   Proportion of clients followed up following discharge.