On 29 January 2005, the Northern Territory Department of Health and Community Services contracted Healthcare Management Advisors (HMA) to undertake the development of the Alcohol and Other Drug Program – Profile of Services and Interventions Project.

1.3 Project deliverables
HMA was required to provide deliverables at the service, regional and Territory levels. At the service level a package that addresses the following for each service that:

- identifies services provided by individual agencies/service providers;
- assesses service provision against current best practice/evidence-based practice;
- makes recommendations about agencies meeting best practice standards; and
- suggests appropriate performance indicators for each type of service.

For each region HMA was to identify:

- the current mix and capacity of services;
- the unmet needs and service gaps; and
- priorities for addressing unmet needs and service gaps.

1.4 Methodology
HMA applied an eight stage methodology to completing the project which involved:

1. Project planning in collaboration with the Department
2. Preparation of a background document that established a basis for classifying services drew together findings from previous work in the Northern Territory and literature regarding indicators of best practice in alcohol and other drug services.
3. A survey was undertaken of all alcohol and other drug agencies identified to support establishment of a consistent data base from which to map services. A total of 18 responses were received, of which one was largely incomplete, providing 17 responses, covering 135 alcohol and other drug positions.
1.5 Purpose and structure of this document

This document represents the final report for the project. The document is structured as follows:

• Chapter 1 provides an overview of the project and methodology;
• Chapter 2 provides a summary of data regarding the need for alcohol and other drug interventions in the Northern Territory;
• Chapter 3 draws on the available literature to describe the components of an effective treatment system and develop a framework for classifying services;
• Chapter 4 provides a description of current services by region, identified gaps and priorities, maps existing services and considers the skills base within alcohol and other drug treatment services in the Northern Territory;
• Chapter 5 provides a brief summary of the available literature regarding best practice that is subsequently used to develop performance indicators in Chapter 6; and
• Chapter 6 provides an assessment of the current operation of services against best practice, recommends a range of performance indicators that the Department may incorporate into funding agreements to support development of best practice and provides recommendations regarding the development and implementation of accreditation.
Summary

The need for alcohol and other drug services in the Northern Territory

The work of the Illicit Drugs Task Force (DHCS 2001) and the Northern Territory Alcohol Framework (NT Treasury 2004) highlighted a need to gain an improved understanding of the range of alcohol and other drug treatment services available in the Northern Territory and the extent to which these services reflected current evidence-based best practice.

Data generated through the National Drugs Strategy Household Survey (AIHW 2001, 2001a and 2005), along with information within the Illicit Drugs Taskforce Report (DHCS 2000) and the Northern Territory Alcohol Framework (NT Treasury 2004), indicated that the per capita consumption of alcohol in the Northern Territory (13.82 litres per annum) is significantly higher than the national average (9.32 litres per annum) with 45.5% of the population consuming alcohol on a daily basis, compared to the national average of 39.5% (AIHW 2002a).

Cannabis use is also significantly more prevalent than nationally (AIHW 2002a), as is injecting drug use.

The high prevalence of alcohol consumption is of particular concern given that its contribution to the burden of disease within the community is fourth only to tobacco, obesity and lack of exercise. The burden of disease associated with cannabis and injecting drug use remain relatively low (Mathers et al. 1999).

Components of an effective service system

Examination of the available literature regarding effective treatment interventions for alcohol and other drug related problems, however, highlights that with the exception of interventions involving medication (detoxification and pharmacotherapies) the substance/s used by clients are of limited importance in determining the effectiveness of interventions. Although the current project is focused on the treatment components of the alcohol and other drugs system in the Northern Territory, it is worth noting that a comprehensive service system should be structured within the new public health model and incorporate universal prevention through to services designed to...
maintain those clients who have developed chronic conditions associated with alcohol and other drug use.

An ideal alcohol and other drug treatment service system is one that:

• provides a continuum of care and includes screening, assessment, early intervention, detoxification, residential and non-residential programs, relapse and aftercare services and family support/coping services;
• provides multiple entry points;
• caters for the needs of potential consumers;
• acknowledges the diversity of needs in communities and regions within the Northern Territory;
• demonstrates effective relationships between service providers; and
• ensures high quality services.

The available literature (e.g. Ali et al. 1992) and recent reports prepared in the Northern Territory such as the Illicit Drugs Task Force Report and the Northern Territory Alcohol Framework provide the following criteria for assessing a service system:

(1) A range of services including screening, assessment, early intervention, detoxification, residential and non-residential programs, relapse prevention and aftercare, and family support/coping services.

(2) Services that are available and accessible to high risk groups including:
• pregnant women;
• Aboriginal and Torres Strait Islander people;
• young people;
• people involved with the criminal justice system;
• people living in remote communities; and
• those with a concurrent mental health problem.

(3) Linkages between services to ensure clients can readily access a continuum of care.

(4) The extent to which services are linked to and reflect the needs of different communities/regions.

A range of characteristics was identified for the description and classification of services to support mapping the current service system. The map of existing services is provided in Chapter 4.

Current services, gaps and priorities

The Darwin Region

Overall, the Darwin Region appeared to be experiencing an increase in hospital separations associated with alcohol consumption, with a slightly greater rate of increase for men than for women. A comprehensive range of services is available, with the majority of personnel providing clinical services holding appropriate academic qualifications and experience. In addition, it was noted that the Department’s efforts to provide specific alcohol and other drug training across the field had been well received and contributed to the skills base available.

Gaps identified in the service system within the Darwin region were:

• services for young people (i.e. under 18 years of age);
• residential services for women, particularly those with children;
• access to additional detoxification beds;
• halfway houses or supported accommodation to facilitate aftercare for clients from residential services; and
• access to community-based services for clients on community supervision orders.

The identified priorities for the Darwin Region, outlined in the order indicated by workshop participants are:
(1) Development of residential services for women.

(2) Development of appropriate services for alcohol and other drug clients with high prevalence mental disorders (e.g. depression and anxiety).

(3) Development of appropriate models for the operation of halfway houses and aftercare services.

(4) Development of appropriate models of care to support clients living in remote communities.

(5) Enhancing co-management systems between alcohol and other drug and mental health services.

(6) Development of appropriate services for young people with diverse needs including alcohol and other drug services.

(7) Enhancing access to services for clients on community supervision orders.

(8) Development of prison based alcohol and other drug services.

(9) Increased residential detoxification capacity.

(10) Development of an effective model for servicing remote communities.

(11) Development of pharmacotherapy services with residential support (similar to the Methadone to Abstinence program operated by We Help Ourselves).

The East Arnhem Region

The East Arnhem Region has limited access to alcohol and other drug treatment services, although review of hospital separations data indicated that separations associated with alcohol use appeared to have remained relatively stable within the region over the past five years. It was noted that a sobering-up shelter and rehabilitation service were being established in Nhulunbuy and that Aboriginal Mental Health Workers employed through the Top End Division of General Practice were receiving additional training to complement the current assessment and counselling service available through the Gove and Darwin AODS teams. The development of an innovative program through Miwatj Aboriginal Health Service, Rapyirir Rom, which involved community elders acting as facilitators to support change in families experiencing difficulties, was also noted.

Advice received while visiting the East Arnhem region suggested that with current developments the range of services available was likely to be sufficient, although some concern was expressed regarding the potential demand for services that may result from expansion of the bauxite mine in the area and the resulting population increase.

The Katherine Region

The Katherine Region has limited access to detoxification, community-based counselling and sobering up services, as well as a residential rehabilitation service which operates within the town. However, there is no access to reliable services in the remote communities within the region.

Hospital separations associated with alcohol use indicate that alcohol is a growing problem for both men and women in the region. Cannabis use was also identified as an increasing issue, particularly in more remote communities, although intravenous drug use was reported to be limited.

Discussions with stakeholders in the Katherine Region identified a number of gaps within the service system and potential solutions, namely:

- services to support remote communities in which alcohol and other drugs were an issue;
- a drop in or support centre for visitor to Katherine from remote communities; and
- consistently available community counselling services.

The Tennant Creek Region

The region centred on Tennant Creek has access to a range of services located in Tennant Creek including detoxification, a sobering up shelter, community-based counselling, residential rehabilitation and aftercare. Hospital
separation data indicated that alcohol related separations had remained relatively constant for both men and women over the five years of data analysed.

It was argued that the primary gaps in the current service system related to the lack of an appropriate model to service the remote communities within the region, and the potential for developing an intensive case management service to support families within Tennant Creek that were experiencing complex problems including alcohol and other drug use. Finally, although it was reported that aftercare was provided following residential rehabilitation, lack of employment within Tennant Creek presented additional challenges. Criminal justice data however suggested that social problems associated with alcohol and other drug use were increasing.

The Alice Springs Region

The Alice Springs Region is characterised by a significant population in Alice Springs and a large number of remote communities. A comprehensive range of services operate in Alice Springs, including sobering up, detoxification, pharmacotherapies, community based assessment and counselling, residential rehabilitation and limited aftercare. In more remote communities it was noted that Hermannsburg and Yuendumu had access to specialised services but that remaining communities were poorly served.

Hospital separation data indicated that the health impacts associated with alcohol consumption were an increasing issue within the region for both men and women. This was also reflected in criminal justice data. Key stakeholders indicated that alcohol was becoming a greater issue in the community, as was petrol sniffing.

Two significant services within the region, the public sector alcohol and other drugs service (ADSCA) and the Central Australian Aboriginal Programs Unit (CAAAPU), were in the process of significant reorganisation. It was argued by a number of stakeholders that the overall range of services within the region did not link effectively to meet needs within Alice Springs. There was broad consensus that remote communities had access to very limited services and that development of an effective model to service these communities was required.

Discussions with key stakeholders and service providers identified a range of gaps within the current service system, specifically:

- development of an appropriate and accepted model to provide services to remote communities in the region and within Alice Springs;
- provision of public sector services in a form that was appropriate and accessible to Aboriginal people;
- development of appropriate options for those inhaling volatile substances;
- effective interaction between alcohol and other drug services and mental health services in managing difficult clients such as those with personality disorders; and
- enhanced linkages between treatment services and other organisations to enhance aftercare, relapse prevention and follow up.

Priorities identified in the course of a workshop held in Alice Springs, listed in the order identified by participants were:

1. Development of appropriate services and service models for remote communities in Central Australia.
2. Developing an appropriate response to inhalant use in Alice Springs involving coordination of current initiatives across the region to address this issue.
3. Training and retention of appropriately skilled personnel within the alcohol and other drugs field.
4. Enhancing interaction and collaboration between mental health and alcohol and other drug services in the management of clients, particularly those with personality disorders.
5. Improving the linkages between alcohol and other drug services and the range of support services required by clients completing treatment.
(6) Enhancing accessibility of public sector alcohol and other drug services to Indigenous people (potentially through purchasing arrangements with the community controlled sector).

(7) Improving the sharing of data between agencies.

(8) Identifying correctional institutions as a key setting for initiating treatment.

Evidence for effective interventions

The current evidence indicates that in order to optimise treatment for alcohol and other drug problems:

- the primary health care sector has a key role to play in the identification of clients at risk of alcohol or drug related harm and provision of brief interventions or referral to specialist alcohol and other drug services;
- assessment should include both formal and informal components and be focused on matching clients to the most appropriate intervention and developing a treatment plan;
- home or community-based detoxification is appropriate for clients for whom there is limited risk or history of severe withdrawal symptoms, no cognitive deficit and a supportive environment;
- interventions should be aligned with clients problems and cognitive style;
- non residential treatment has comparable effectiveness to residential treatment for clients with a social network that does not support continued drinking or drug use;
- residential treatment is appropriate to clients who lack stable housing, social support and a supportive primary relationship;
- for clients with cognitive deficits programs should be highly structured and behaviourally based;
- clients receiving pharmacotherapy should as far as possible be retained in treatment for an extended period and be provided with cognitive behavioural and skills based interventions as an adjunct to medication;
- a process of reintegration for clients leaving residential treatment is of benefit;
- follow up for all clients should be arranged in the course of treatment;
- ideally clients should be supported to establish links with appropriate and relevant ancillary services prior to completion of treatment; and
- interventions in Indigenous communities require the support and involvement of the local community if they are to be sustainable and effective.

This evidence base underpins the performance indicators proposed as a result of the current project.

Current practice

Site visits and discussion regarding current practice and its relationship to evidence-based best practice, indicated that there was a consistently good understanding of the current evidence base, which in part reflected the priority that had been placed on increased skills within the workforce over the past five years.

The assessments utilised by services were comprehensive and included both formal and informal components. It was consistently indicated that assessments were utilised to develop treatment plans and support matching clients to appropriate interventions. However, it was noted there was limited capacity to assess cognitive function. CAAAPU had been developing an innovative assessment approach for Aboriginal people from remote communities, however as the current project was drawing to a conclusion it was reported that the key staff developing the assessment approach and related program had left the organisation.

Analysis of the Alcohol and Other Drug Treatment National Minimum Dataset (NMDS) data suggested that case management had decreased over the past three years to the point where it was either unreported or unavailable, while the number of assessment only cases had
increased. It was unclear whether this reflected poor implementation of assessment procedures, that services were unable to implement case management as a treatment modality or that there were issues with data definition and recording.

Discussions with services indicated a good knowledge of the need to match interventions to clients’ needs. Service providers consistently reporting that living skills training targeted those areas clients agreed represented deficits, and provision of options even within relatively formal residential and community based programs, for individual counselling and support to access specific services externally.

Service providers involved in discussions uniformly understood the importance of incorporating harm reduction into treatment, although it was noted that in the non-government sector this represented an ideological challenge for some boards. Where agencies indicated that they specifically offered case management, it was noted that these service had developed close working relationships with a wide range of service providers from mental health services, through to housing and employment providers. It was argued in a number of cases that application of a case management approach to small communities represented a potential avenue for increase in the services provided.

Sobering-up and community patrol services appeared well linked with services and it was reported that the operation of the Community Harmony Program had contributed to activity in case management from this perspective.

Detoxification services were identified as operating effectively and actively applied consistent, evidence based guidelines and protocols for assessment and management of withdrawal. Although some informants argued that there were insufficient beds available for detoxification in Darwin and Alice Springs, in many cases this appeared to reflect a poor understanding of existing services, or resistance to the notion of home or outpatient detoxification.

Pharmacotherapy services are governed by an extensive range of legislation and clinical guidelines. As compliance with these requirements was reported, it was also assumed that these services were operating in line with current best practice, although the facilities for administering medication in Darwin were considered inappropriate.

Community-based services had the most highly qualified personnel, and appeared to consistently provide interventions that were structured, drawn from a sound theoretical base and reflected the current evidence base.

Residential rehabilitation services largely reflected evidence-based best practice, providing comprehensive assessment, incorporating a focus on living skills and relapse prevention, establishment of appropriate support for reintegration into the community, and inclusion of individualised treatment into their broader programs. However, it was noted that in some cases the services appeared relatively fragile, with progress towards and maintenance of best practice dependent on one or two individuals.

When considering the range of services required for an ideal alcohol and other drug treatment system, it appeared that as a whole the Northern Territory had access to the full range of services, particularly in Darwin and Alice Springs. However, in smaller regions it was noted that the range of services was limited to sobering-up, residential rehabilitation and limited access to detoxification. Community-based counselling was often affected by difficulties recruiting to these regions and there was limited, if any, need for pharmacotherapy.

It was noted in a number of discussions that government alcohol and other drug services did not always operate in a manner that was accessible or considered appropriate for Aboriginal people. Similarly, for women requiring treatment all services reported allocation of female counsellors to female clients, although there was limited access to residential rehabilitation for women, and particularly women with children.

People in remote communities were consistently identified as having limited if any access to alcohol and other drug treatment. This reflects the logistics involved in serving remote communities and the need to
develop service models which address these challenges. However, the approach taken by Centacare, and that being developed in East Arnhem appeared to provide some promise.

The development of the CREDIT program has increased the number of clients receiving treatment with some form of coercion. Discussions with service providers indicated that there were robust systems in place to ensure that clients understood the basis of their orders, the impact this had on confidentiality, and the repercussion of failing to comply with the order under which they were placed. Again, this was consistent with the evidence base for managing this client group.

It was consistently reported that management of clients with concurrent mental disorders or mental illness represented a significant challenge for services and that considerable progress was still required in implementing effective collaborative arrangements between mental health and alcohol and other drug services.

At an organisational level, it was evident that government services employed more highly qualified personnel, although site visits and survey responses indicated that few organisations now employ individuals who have no alcohol or other drug related qualification. The provision of training by the Department appeared to have gradually raised the skill levels across the sector. Clinical supervision was most organised in government services and community-based counselling service with tertiary qualified staff, although all agencies reported some activity in this area.

Across agencies there appeared to be a growing focus on formalising policies and procedures within organisation and there was interest in the potential benefits of agreed standards and an accreditation process.

Performance indicators

Performance indicators provide a means to determine the extent to which progress has been made or maintained in achieving particular objectives. Within the context of the current project, a range of performance indicators have been developed to reflect the extent to which the current evidence base for effective alcohol and other drug interventions is to be applied.

The following performance indicators were developed with a view to inclusion in funding agreements between the Department and service providers to support ongoing improvement of the quality of services provided. The proposed performance indicators are outlined below, against each service type.

**Performance indicators for Primary Health Care**

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 formally referred to specialist alcohol and other drug services.
4. Proportion of clients referred for specialist alcohol or other drug services returning without having acted upon the referral.

**Performance indicators for Assessment**

1. Proportion of clients contacting the service requiring other than brief intervention who receive a comprehensive assessment.
2. Proportion of primary clients (i.e. those using alcohol or other drugs) 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.

(6) Proportion of clients provided with information about alcohol and other drug related harm and available services.

**Performance indicators for sobering up shelters**

(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 and respond to clients entering withdrawal.

(4) Proportion of clients absconding within six hours of admission.

(5) Proportion of clients receiving brief interventions.

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.

(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.

(7) Proportion of clinical staff engaged in clinical support and review processes.

(8) Proportion of staff with at least minimum academic and professional qualifications for their role.

Proposed indicators for detoxification services are:

(1) Proportion of clients assessed by detoxification services experiencing risk factors, such as 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 for whom follow up subsequent to detoxification was attempted.

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

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) Proportion of personnel providing pharmacotherapy with at least agreed minimum qualifications and experience.

(5) Proportion of clients referred for pharmacotherapy and assessed as appropriate for whom a treatment position was not available.

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 clients achieving 50% of their treatment goals.

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

(7) Proportion of clinical staff receiving structured clinical supervision.

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 agreed qualifications.

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.

**RECOMMENDATION 1.**

It is recommended that the Department of Health and Community Services consider the introduction of the range of performance indicators outlined above into funding agreements with alcohol and other drug services in the Northern Territory.

**Implementation of Standards**

Three options for pursuing standards for alcohol and other drug services in the Northern Territory have been suggested, namely:

(1) Application of an accreditation program using externally established standards and assessment procedures.

(2) Incorporation of an increasing number of standards and performance indicators negotiated between services and the Department, although with a consistent range of standards applied to all services.

(3) Development of a set of standards agreed by all alcohol and other drug services in the Northern Territory, with self assessment and certification that these standards are achieved as a component of funding agreements with the Department.

Discussions with all stakeholders indicated that there was consistent support for the establishment of standards for alcohol and other drug services and introduction of accreditation, provided that the process was staged and resources were available to support the process. Accordingly, it is recommended that:

**RECOMMENDATION 2.**

It is recommended that the Department establish a working group with alcohol and other drug agencies in the Northern Territory to agree on a time frame for the implementation of standards, and key standards to be achieved in the coming year.
RECOMMENDATION 3.
It is recommended that the Department in consultation with service providers consider utilisation of the standards developing through QMS as they provide a specific focus on community based services and alcohol and other drug services.

RECOMMENDATION 4.
It is recommended that a timeframe of three years be agreed for agencies to initiate formal application for accreditation, and that all agencies be required to achieve accreditation within five years.

RECOMMENDATION 5.
It is recommended that programs established in Indigenous communities that do not reflect a traditional service delivery structure and that would not readily align with the assumptions underpinning mainstream standards and accreditation not be required to commit to accreditation, but that where these initiatives receive funding, key indicators such as those proposed by Stremel (et al. 2003) be utilised to monitor service or program quality.