

**This chapter provides an outline of the framework utilised by HMA in considering the extent to which current practice aligned with the evidence base for best practice. At the outset it should be understood that the focus of the analysis is at the system, rather than the individual service level. Accordingly identifying services which represent examples of poor practice has been avoided, while services which demonstrated good practice have been identified to allow other services to seek their advice and support to improve specific areas of practice.**

### 6.1 Framework for assessing best practice

The project methodology was not designed to include detailed practice audits of all organisations visited. Rather, a check list of indicators of best or better practice was used which relied upon the application of specific service components and the relationship between components from assessment through to aftercare and discharge.

The key areas of interest within the framework were:

- extent to which assessment incorporated both formal and informal elements to provide a comprehensive base from which to determine appropriate services for the client;
- involvement of clients in the assessment process and establishment of a treatment plan or treatment goals;
- use of assessment to match clients to interventions (i.e. more intensive interventions for those with greater dependence or skills/social deficits or providing no residential services to clients with stable family and social environments);
- the application of a coherent framework for counselling that emphasised an effective therapeutic relationship;
- utilisation of clearly articulated treatment plans developed in collaboration with clients;

- incorporation of a variety of treatment goals aligned with clients needs and preferences;
- inclusion of harm reduction strategies into treatment;
- effective case management systems with client consent and effective interaction with other professionals;
- inclusion of key practice elements in specific interventions (e.g. detoxification, pharmacotherapies, residential rehabilitation and sobering-up);
- responsiveness to the needs of specific client groups (e.g. female counsellors for women, culturally safe intervention for Indigenous people and involvement of mental health specialist for those with an active mental disorder); and
- organisational infrastructure (e.g. clear policies regarding confidentiality, appropriately qualified staff, effective clinical supervision and staff development and appropriate facilities).

The survey of agencies and the discussions during site visits sought to gain information regarding the operation of services against these areas that were derived from the indicators of best practice developed by Dale and Marsh (2000).

### 6.2 Current practice

This section outlines our findings regarding the current alignment of services provided within the Northern Territory alcohol and other drug intervention system. Our findings are organised against components of intervention, namely:

- overall program structure;
- assessment;
- treatment selection and planning;
- incorporation of harm reduction;
- approaches to case management;
- intervention modalities;
- response to specific client groups; and
- organisational infrastructure.

### 6.2.1 Intervention service/program structures

A key feature of site visits, and component of the survey, sought to confirm that there was a coherent structure within the service provide by each agency, commencing with assessment and concluding with referral to another service or discharge and follow-up.

All services visited were able to provide a clearly articulated outline of the logic underpinning the service they offered clients, linking:

- assessment to determining suitability of clients to the service provided and treatment planning;
- treatment plans to components of the intervention regime and provision of options to respond to individual needs and goals;
- harm minimisation and relapse prevention into the overall intervention approach and treatment plans;
- liaison with external ancillary organisations and discharge or aftercare planning; and
- discharge or treatment plans and client follow-up.

Given the content of current funding agreements between the Department and individual agencies include activity indicators that imply linkage between components of each service, this was not surprising.

However, the structure of, and relationships between night/day patrols, sobering up shelters and ancillary services, particularly in Darwin, Nhulunbuy (though still being developed) and Alice Springs was identified as a particular example of overall program design reflecting evidence based practice. Discussions suggested that the development and implementation of the Community Harmony Strategy had in part contributed to this, for instance in the relationships developed between Mission Australia and The Larrakeyah Nation Information and Referral Centre, and the

collaboration between the ADS in Nhulunbuy and Miwatj related to the Rapyirri Rom program.

### 6.2.2 Assessment processes

All service visits and survey responses received indicated that the level of assessment undertaken by agencies was appropriate to the services provided. Sobering up shelters and community outreach services primarily seeking to identify and respond to the immediate needs of clients to minimise harm and promote opportunities for intervention.

More intensive services such as detoxification, counselling, community based and residential rehabilitation services undertook more formal assessment process which in most cases included:

- a comprehensive history (social, drug use and to a lesser extent medical);
- consideration of willingness to change and incorporation of motivational interviewing;
- screening for suicidal ideation;
- one or more formal tools to assess level of dependence (e.g. AUDIT or SADQ-C);
- where psychologists were employed additional tools such as DASS21 were utilised;
- client consent was sought for use of the information, collection of additional information and initiation of treatment/ intervention;
- feedback regarding the assessment was provided to clients; and
- clients were engaged in determining goals for intervention and the extent to which the service could facilitate achievement of these goals.

It was evident from review of survey responses and discussions during site visits that a considerable focus has been placed on training workers in the alcohol and other drug sector by the Department, which may explain the consistency of responses. In addition, numerous references were made to assessment tools developed by Turningpoint, suggesting that the Clinical Advisory Service is

contributing to the development of skills within the sector.

However, given the prevalence of alcohol use in the Northern Territory, and despite the comparatively young population, the potential for clients to experience varying levels of cognitive impairment resulting from alcohol use, there was limited awareness or capacity to screen or test for this deficit. Given the potential impact on selection of and response to treatment approaches, this was identified as an area that may require further development.

The assessment approach being developed through CAAAPU was identified as particularly interesting in that it sought to translate current best practice for assessment into a culturally appropriate form for Aboriginal people from central Australia. The approach used drawings and other non verbal tools to facilitate exploration of issues impacting on alcohol or drug use and the development of treatment goals.

In reviewing NMDS data, it appeared that very few cases where treatment was ceased resulted in referral to another service (approximately 2%), even where assessment was the main treatment type provided. This may reflect clients selecting agencies that may meet their needs following advice from colleagues or other service providers, or highlight the need for greater collaboration between services. The fact that the proportion of those referred did not change where assessment only was identified as the main intervention suggests that the latter may be the case.

### **6.2.3 Treatment selection and planning**

Although all agencies visited or that submitted survey response indicated that assessment contributed to treatment planning there was some variation in the extent to which this was achieved across different service types. The flexibility available to counselling services where there is a greater focus on individual interventions allowed assessment and negotiation with clients to develop highly tailored treatment plans establishing goals, strategies for their achievement and indicators to assess progress. It is also worth noting that

this type of service was also more likely to have staff with university qualifications in psychology or related disciplines providing a more extensive skills and knowledge base from which to draw in designing interventions.

Residential services and formal community based rehabilitation programs have less flexibility and generally require clients to progress through a relatively standardised program. However treatment plans in these services provided for a greater emphasis on individual components of a program and the use of individual counselling sessions or referral to specific ancillary services to respond to varying needs and goals amongst clients.

Again, the investment in enhancing the skills within the alcohol and other drugs workforce appears to have contributed to the consistent understanding of the need to plan treatment to address individual client needs and goals.

### **6.2.4 Incorporation of harm reduction**

Discussions with all agencies indicated that the importance of incorporating harm reduction as a core component of services was essential. A wide range of strategies were identified, including:

- focus on managing or reducing alcohol related violence (e.g. Rapyirri Rom);
- provision of an alcohol free day program in Alice Springs (CAAAPU);
- provision of safe alcohol or drug use education in residential rehabilitation centre; and
- inclusion of nutritious breakfasts and clean clothes in sobering up facilities.

### **6.2.5 Approaches to case management**

Site visits indicated that case management was applied to varying degrees across agencies and service types. Discussions suggested that this in part reflected the needs of clients and the types of clients utilising different types of service.

In residential rehabilitation programs, such as BRADAAG, it was indicated that support and case management was viewed as an

integral part of the service and developing an effective discharge program with clients. Case management in this case involved collaboration with Centrelink, TAFE, local voluntary organisations, housing services and CDEP to arrange a comprehensive support structure for clients.

In community based services, such as Amity House, it was noted that most clients have limited need for case management, though where there were concurrent issues such as mental health problems collaborative arrangements were established with the Tamarind Centre and local GPs. Of interest, discussions with this service regarding development of initiatives to better respond to the needs of Aboriginal people implied a case management at a community level.

Sobering-up and community patrol services appeared to be active in linking clients to a wider range of services.

Of interest, the NMDS indicated that support and case management as a main treatment type had declined from 111 episodes in 2001 to 21 episodes in 2004. It is unclear if this reflects a change in coding activity on the part of agencies, changed conceptualisation of services that might be considered case management or reduction in activity in this area.

### 6.2.6 Intervention modalities

The sobering-up shelters visited in the course of the project were uniformly impressive in the extent to which they embodied current evidence based best practice, providing a safe environment, a shower, clean clothes, information and where possible brief interventions. In addition, the links with other support services and opportunistic follow-up of clients through outreach services or community patrols appeared relatively structured and consistent.

Although no counselling sessions were observed, advice provided by agencies operating counselling services indicated that all community based counselling services visited:

- linked clients with appropriate services whilst client is still engaged with their service;

- emphasised working with clients to develop strategies to cope with difficulties before they arose;
- incorporated specific interventions for which an evidence base is available (e.g. goal setting, motivational interview and problems solving);
- worked with client to identify positive internal and external resources and successes as well as problems and disabilities;
- where appropriate, involved a key supportive other to support behavioural change outside the therapeutic environment.

Both Holyoake and Centacare operate group based counselling programs that were relatively structured. Discussions with both services regarding the content and operation of their programs, as well as individual counselling suggested that the approaches were consistent with current evidence. Of particular interest, the service coordinated through Centacare in Wadeye, Milikapiti, Nguuiu and Pirlangimpi appeared to enjoy strong support within the communities and provide a further model for the provision of intervention in remote, Aboriginal communities.

A number of agencies indicated that they provided brief interventions, such as information, education and motivational interviewing where assessment indicated that clients did not require a more intensive intervention, which is consistent with available evidence. This may serve to explain the relatively high proportion of clients (98%) who received assessment only but were not recorded as being referred to another service, though evidence of this was not collected in the course of the project.

Although some concerns were voiced regarding access to detoxification beds following restructuring of services, all those interviewed suggested that the current detoxification service offered through the Department's Alcohol and Other Drug Service provided a high quality service that responded effectively to clients' needs and applied good clinical practice. Despite the concerns raised by some

stakeholders regarding access to the service for those without a stable residential environment, the approach to supporting beds in residential services such as ANSTI, CAAPS and DASA appeared to meet current demand in major centres. However, indicators such as hospital separations and criminal justice data suggest that demand can be expected to increase.

The availability of detoxification in regional and remote communities was limited and it was noted that hospitals are often unable or reluctant to admit patients for detoxification unless the admission relates to an acute condition. This again highlights the need to develop systems or approaches that respond to the needs of more remote communities.

The introduction of pharmacotherapies is relatively recent in the Northern Territory. Given the level of regulation regarding the operation this type of service there was a high degree of confidence that the service was operating in line with the current evidence base. However the physical environment in which dispensing occurs in Darwin was identified as less than optimal for clients.

Advice received in the course of site visits and consultations indicated that residential rehabilitation services incorporated a range of activities which are aligned with the current evidence base regarding best practice including:

- ensuring residents receive a comprehensive medical assessment and initiate treatment for identified conditions (e.g. CAAPS uses Danila Dilba for this service while CAAAPU utilised Central Australian Aboriginal Congress);
- provided some employment, education and skills training though it was unclear to what extent this occurred based on site visits and discussions with a small number of external stakeholders;
- life skills training (cooking, budgeting, cleaning and managing a household);
- the CAAPS program accepts children and Banyan House will soon do so with programs in both services designed to enhance parenting skills;

- provision of links and support to engage with non alcohol or other drug using community groups and activities of interest;
- support access to services such as mental health and legal services where appropriate; and
- operation of a component of their program to assist clients to plan and implement strategies to support reintegration into the community.

However, it consistently noted that the provision of follow-up or aftercare was often beyond the resources of services and that where clients came from remote communities, follow up, other than by telephone was impractical.

### **6.2.7 Response to specific client groups**

The proportion of the Northern Territory population identified as Aboriginal is to some extent reflected in the current service system. Services operated by Aboriginal community controlled organisations such as CAAPS and CAAAPU had developed approaches that appeared attractive and appropriate to the needs of this group. It was also noted that the Social and Emotional Well-Being Services operated through Aboriginal Medical Services provided a significant access point for alcohol and other drug interventions. The assessment approach being developed at CAAAPU, the inclusion of families in treatment at CAAPS, and the developments occurring in East Arnhem suggest that the evidence base for effective interventions for Indigenous people in the Northern Territory will grow.

Nevertheless, it was noted in a number of discussions that mainstream alcohol and other drug services have not consistently sought to provide services that are appropriate to Aboriginal people, and that where this is the case movement of personnel or resources, or perhaps closer working relationships may improve this area of services.

Associated with the provision of appropriate services for Aboriginal people is the accessibility of service to those in remote communities. As noted previously, while residential rehabilitation at some urban centres may provide clients



with respite from factors which contribute to their substance misuse, and also provide communities with respite from violence and disruption caused by those abusing alcohol or other drugs, effective systems of follow-up and aftercare are problematic. The development of local indigenous health workers with skills to respond to alcohol and other drug problems, along with models such as that developed by Centacare, may provide a future direction, though there is no evidence at this point to suggest that these approaches will be easily transferred.

In the course of consultations it was noted that resources may be available in Central Australia for a service to support remote communities but that the structure and governance of such a service was still being considered by stakeholders.

The comparatively high use of alcohol amongst women in the Northern Territory suggests that the need for services which provide female counsellors are in environments where women are, and can feel safe. Further provision of services that accept women with children was identified as a need within the Northern Territory.

Those services visited that accept both men and women consistently advised that separate accommodation is provided for women, that women's only groups operate when there is more than one female client and that female counsellors are provided for female clients. Accordingly it appeared that those services who do treat women sought to apply current evidence regarding the different service requirements of this group.

The establishment of CREDIT and the increased efforts of the criminal justice system to divert or direct offenders with alcohol and other drug problems to treatment has seen this group increasingly represented in the treatment population. Discussions with services involved in treating this group indicated that their services:

- clearly understood and informed clients of the limits of confidentiality and information that would be provided regarding their progress or compliance;

- balanced the need to provide advice to the sentencing or supervising authority while also maintaining clients confidence; and
- the need to focus on providing clients with the skills to reduce the harm caused by their alcohol or other drug use should they continue to use.

A key concern for residential services was balancing the proportion of clients within their service at any time from the criminal justice system with voluntary clients.

Management of clients with concurrent mental health and substance use problems appeared to be an area in which further development was required. Although it was noted by a small proportion of services that there was active referral of clients between services, the general theme in discussions suggested that collaboration between the two fields is variable, and appeared dependent on personal relationships between individuals.

### 6.2.8 Organisational infrastructure

A range of organisational factors have been identified by Dale and Marsh (2000) and more recently by Stremmel et al. (2003) that contribute to the effective provision of alcohol and other drugs services and are discussed below.

Confidentiality is a key consideration within the health sector and particularly in the alcohol and other drugs field if clients are to establish the trust required to actively participate in treatment. On the basis of site visits and survey responses it appeared that all agencies had established policies and procedures related to client confidentiality.

The ongoing professional development and clinical supervision of staff employed in alcohol and other drug services has been identified as a key contributor to the provision of high quality care and application of evidence based practice. It was noted from site visits and survey responses that achievement of, or progress toward the Alcohol and Other Drugs Certificate IV was a requirement for employment in the majority of services. This appeared to reflect the

availability of training through the Department and acceptance within the field that employment of trained (or training) workers enhanced service delivery.

Government services and community based counselling services appeared better placed to recruit more highly qualified personnel overall, though it was noted that there were a wide range of a skill levels within residential services, ranging from degree qualified staff with additional training in the alcohol and drug field to personnel with personal experience who were undertaking the Certificate II or III course. This may be related to differences in the employment conditions between the government and non-government services and the lack of shift work for community based counselling services.

In the course of site visits it became apparent that there was also considerable variation between services in terms of the level of clinical or professional supervision. At one end of the spectrum a community based counselling service provided staff with access to paid supervision with a supervisor of choice, with telephone supervision where the supervisor was not a resident in the Northern Territory supported by regular peer review meetings, conference attendance and support for ongoing training. At the other end of the spectrum supervision was limited to case discussions with the most senior member of clinical staff.

It appeared that there may be potential for supervision across services, particularly given the skills base within government operated services, with an example identified in Nhulunbuy where support, training and supervision were provided to alcohol and other drug workers located in Yirrkala.

Discussions with services visited in the course of the project suggested that all services had either developed, or were in the process of developing comprehensive policy and procedure documents to formalise internal processes and increase the consistency of the services provided. Indeed, when discussing future directions for alcohol and other drug services in the Northern Territory there was broad agreement that the establishment of

agreed standards and accreditation to these standards would be a positive development.

In one case it was noted that the service had undergone a significant process of change over the past two years and that for the board adoption of evidence based practice presented significant challenges. It was argued that the establishment of standards, while providing a base form which senior staff within non-government services could guide their board, may also require the provision of training to board members.

Related to each of the above issues (staff development/supervision and established policies and procedures) the operation of a coherent quality management or improvement system is identified in the literature as a core component of best practice. It appeared that current funding agreements had provided a starting point for services to measure activity and monitor improvements in access and some aspects of service delivery. There was considerable enthusiasm for accreditation in the longer term as a means by which agencies and personnel could gain feedback regarding improvements in the service they provided.

### 6.2.9 Conclusion

On the basis of survey responses and site visits it appeared that considerable progress had been made within alcohol and other drug services in the Northern Territory to implement evidence based best practice.

Although the methodology for the current project did not involve detailed clinical audit of each service it was apparent that services aligned with best practice in the following areas:

- the majority of services, other than sobering up services (which provide a limited but appropriate assessment), utilised a comprehensive assessment that included both formal and informal components;
- there was a clear link reported between assessment and treatment planning;
- clients were involved in treatment planning and received feedback regarding assessment;

- counselling services appeared to be cognizant of and apply best practice, perhaps due to the relatively higher academic qualifications within this sector;
- in residential programs assessment had less impact on overall treatment, with variation between clients managed through individual counselling;
- all site visits and survey responses indicated that inclusion of harm reduction into all services had occurred;
- detoxification services were uniformly identified as well aligned with current evidence based best practice;
- the provision of case management appeared to be relatively selective in community based counselling and NMDS data suggested this activity had declined across the Northern Territory;
- residential rehabilitation programs predominantly provided a mix of interventions, life skills training and after care planning support, which though consistent with best practice appeared less than systematic in organisations;
- services for women appeared somewhat under represented, though where agencies treated both male and female clients efforts were made to provide a safe environment and access to female groups and counsellors, a number of services accepted women with children and families;
- a range of innovative approaches to providing culturally appropriate services for Aboriginal people were being developed within Northern Territory agencies; and
- the needs of coerced prisoners appeared to incorporate clear communication with clients regarding the implications of their order, and effective management of confidentiality was reported; and
- management of clients with mental disorders presented a challenge to the vast majority of services.

At an organisational level, it was evident that government services employed more highly qualified personnel, though 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, though 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.

### 6.3 Development of performance indicators

Review of current funding agreements indicated that services currently report against a range of activity indicators, such as:

- number of clients seen;
- number of referrals made;
- occupancy rate; and
- number or proportion of clients provided with assistance to return home.

In developing performance indicators, it is necessary to also define targets or objectives against which performance can be measured. As was discussed in Chapter 4, the needs and priorities in each region differ, which in turn should influence the areas in which changes in activity or service effort are required. In addition, performance indicators provide an opportunity to assess change in the extent to which services increasingly adopt best practice. Two potential types of indicators are therefore discussed below, with options for specific indicators proposed in the following section designed to support ongoing monitoring of the application of current best practice within funded alcohol and other drug treatment services.

### 6.3.1 Performance in relation to service need or priorities

As outlined in Chapter 4, the apparent needs in each of the five regions differ, which in turn implies differing priorities. Accordingly the following performance indicators are proposed for use at a system or territory wide level to monitor progress in addressing the identified priorities.

- (1) An increase in the proportion of clients receiving treatment for alcohol and other drug problems in the Northern Territory that are women.
- (2) Proportion of clients with high prevalence mental disorders receiving appropriate co-management.
- (3) Increase in the proportion of clients assessed as likely to benefit from aftercare who received aftercare and follow-up.
- (4) Increase in the proportion of alcohol and other drug clients with major mental disorders co-managed with specialist mental health services.
- (5) Increase in the proportion of Aboriginal people undertaking treatment for alcohol and other drug problems.
- (6) Increase in the proportion of prisoners for whom alcohol and drug use contributed to their offence receiving treatment whilst in prison.
- (7) Increase in the number and proportion of clients from remote communities accessing alcohol or other drug services (this will require modification of the minimum dataset to include client postcode).
- (8) Increase in the proportion of clients completing residential rehabilitation linked to employment, health and welfare services prior to discharge.
- (9) Increase in the proportion of alcohol and other drug personnel with the agreed minimum qualifications for their position.

- (10) Reduction in the proportion of alcohol and other drug positions vacant for more than 3 months.

### 6.3.2 Agency/service level performance indicators

Based on the summary of the available literature relating to best practice interventions for alcohol and other drug use, a range of performance indicators for specific service types were developed in the course of the project to provide a basis for reviewing the extent to which services were achieving best practice. For ease of reference, the performance indicators outlined below are presented in the same order as the summary of current evidence presented in Chapter 5 (above).

#### *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 6 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 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 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.

### 6.3.3 Future directions for performance indicators and funding agreements

The provision of funding by government, and the negotiation of the basis upon which funding is given, provide an ideal location for the introduction of performance indicators to support the ongoing development of alcohol and other drug services in the Northern Territory.

#### **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.*

### 6.4 Implementation of standards

A key focus arising from both the Illicit Drugs Task Force and Northern Territory Alcohol Framework reports indicated the need to establish the quality of services provided by alcohol and other drug services. As a result, a component of the current project was focused on exploration of options for implementing standards for alcohol and other drug services in the Northern Territory. Three potential options were considered and presented to workshops in Darwin and Alice Springs.

#### 6.4.1 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. Examples of models discussed at workshops included the Equip system used by the Australian Council of Health Care Standards, the Alcohol and Other Drugs Standards developed by Quality Management Services (formerly CHASP) and ISO 9000. In addition, it was noted that 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 three to four years after introduction.

- (3) Identification of resources to offset the cost of the 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.

A range of strengths and weaknesses for this approach were discussed with workshop participants and are outlined in Table 6.1.

There was consensus amongst workshop participants that an external accreditation regime was a desirable longer term option. However, it was consistently argued that unless a considerable pool of resources were made available to support services achieving accreditation quickly, immediate introduction of this approach would be beyond the capacity of most services and therefore undermine current support for introduction of standards and accreditation.

#### 6.4.2 Inclusion of best practice standards in funding agreements

An alternative to establishing an external accreditation process discussed with workshop participants was for funding agreements to

include specific standards, and indicators for achievement by agencies. The work of Dale and Marsh (2004) 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 and weaknesses of this approach that were discussed during workshops are summarised in Table 6.2.

Workshop participants consistently argued that while this option presented an appropriate starting point for a move to introduce standards and accreditation, it was not the ideal, and that if this option were accepted it should be viewed as the first step in a process to move to external accreditation.

**Table 6.1: Strengths and weaknesses developed by Quality Management Services**

| Strengths   | Weaknesses   |
|---|--|
| <ul style="list-style-type: none"> <li>• Provides a structured, independent approach to assessing the standard of operation of individual agencies;</li> <li>• Limits concerns regarding potential conflicts of interest in assessing the standard of service provided by individual service or agencies;</li> <li>• Involves an approach that is consistent with other sectors of the health system;</li> <li>• Facilitates establishment of a baseline from which each service can progress; and</li> <li>• Ensures that all agencies or services are assessed objectively and consistently.</li> </ul> | <ul style="list-style-type: none"> <li>• Represents a significant additional cost to services to pay for external review and accreditation;</li> <li>• May result in significant costs to the Department to allow agencies to undergo accreditation and achieve the required standards;</li> <li>• Capacity of external reviewers to fully appreciate the operating environment of agencies in the Northern Territory;</li> <li>• Limited control within the Northern Territory regarding the development and application of standards; and</li> <li>• Ongoing cost and requirement of maintaining accreditation.</li> </ul> |

**Table 6.2: Strengths and weaknesses of the best practice standards approach**

| Strengths   | Weaknesses   |
|---|--|
| <ul style="list-style-type: none"> <li>• Allows standards to be implemented iteratively;</li> <li>• Engages the Department and individual services in negotiation of specific standards to be applied;</li> <li>• 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;</li> <li>• Links achievement of standards to funding; and</li> <li>• Ensures regular review of progress to achieving standards.</li> </ul> | <ul style="list-style-type: none"> <li>• Requires more complex negotiations between the Department and individual agencies;</li> <li>• The negotiation and monitoring process may have resource implications for both agencies and the Department;</li> <li>• Variation between agencies and the requirements within their funding agreements may contribute to perceived favouritism toward some agencies;</li> <li>• 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</li> <li>• 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.</li> </ul> |

### 6.4.3 Establishment of a self regulating 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) provide 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.

Strengths and weaknesses present during workshops are summarised in Table 6.3.

This option was unanimously rejected by workshop participants as it failed to provide a strong basis for the ongoing development of alcohol and other drug services.

| Strengths   | Weaknesses  |
|---|---|
| <ul style="list-style-type: none"> <li>• Provides a flexible approach to implementing standards that allows agencies' priorities to be reflected;</li> <li>• Minimises the costs involved in implementation of standards;</li> <li>• Reduces the need for continual review and monitoring of standards;</li> <li>• Provides a basis for reviewing agencies where concerns have been raised regarding the standard of services provided;</li> <li>• Places responsibility with agencies for compliance.</li> </ul> | <ul style="list-style-type: none"> <li>• Requires development of a forum in which agencies can agree a code of conduct that is accepted by the Department;</li> <li>• Allows idiosyncratic interpretation and application of the agreed code of conduct;</li> <li>• Establishing a case for auditing a service where concerns have arisen may be difficult;</li> <li>• The cost of auditing individual services when required may be significant; and</li> <li>• Responding to concerns regarding individual agencies may result in an adversarial climate developing.</li> </ul> |

Service providers emphasised that developing the infrastructure required to meet standards, such as Equip, would require additional resources to prepare the required documentation and establish systems required to meet the standards. It was also noted that the cost of review for accreditation was potentially beyond the resources of agencies and that additional funding would be required.

The workshop groups also expressed the concern that for some programs developing in Aboriginal communities, where the approach largely involved community development or community action, the constructs underpinning accreditation may be inappropriate, particularly where initiatives have been generated within the community and rely on local community members for their operation. However, it was also stressed that where an Indigenous organisation or community sought to provide an intervention service it should be required to participate in accreditation.

**RECOMMENDATION 2.**

*It is recommended that the Department establish a working group with alcohol and other drug agencies in the Northern Territory to agree to a time frame for the implementation of standards, and key standards to be achieved in the coming*

**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.*

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