NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF **HEALTH**

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Reducing Addictive Behaviours Select Committee
C/- Legislative Assembly
Parliament House
Darwin NT 0800

Dear Select Committee Members

Re: Department of Health Written Submission to the Reducing Addictive Behaviours Select Committee

Please find the Department's formal submission to the Reducing Addictive Behaviours Select Committee as Attachment A.

This submission expands in greater detail the information presented verbally at the Select Committee's Public Hearing on the 30th August 2018 by the Senior Director Mental Health Alcohol and Other Drugs, Cecelia Gore.

Yours sincerely

Professor Catherine Stoddart

DEPARTMENT OF
HEALTH

Submission to the Select Committee on Reducing Addictive Behaviours

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Contents

1 Introduction

The economic, social, health and legal costs of drug use in the Northern Territory are significant and impact across all walks of life. Harms related to tobacco, alcohol and cannabis are disproportionately higher in the Aboriginal and Torres Strait Islander population in comparison to the general population.

The harms from alcohol and other drug use impact on individuals, families, businesses and communities. This includes health harms such as injury, lung and other cancers; cardiovascular disease; liver cirrhosis; mental health problems; road trauma; social harms including violence and other crime. It also includes economic harms from, loss of business and tourism, impacts on education and employment opportunities; healthcare and law enforcement costs,; decreased productivity, associated criminal activity, reinforcement of marginalisation and disadvantage, domestic and family violence and child protection issues. Harmful drug use is also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown.

Drug-related crime impacts on the victims of crime and their families, but it also impacts on wider community perceptions of public safety. Increased illegal drug use in the community impacts heavily on a range of service providers, community groups and service providers including, but not limited to, ambulance services, hospital emergency departments, Police, and community sector organisations (suicide prevention, mental health, community legal aid services).

2 Existing NT frameworks for reducing individual and social harms associated with addiction to illicit drugs, alcohol, tobacco and gambling

How is harm reduction different from other approaches? It is characterised by pragmatism, compassion and a focus on the actual harms which can be addressed. In some initiatives, this means that the focus is not the reduction of the drug use itself (eg needle exchanges) – but the reduction of consequences of the drug use. Harm Minimisation is encompassed within three pillars; demand reduction, harm reduction and supply reduction. Demand reduction approaches seek to prevent the uptake and/or delay the onset of the use of alcohol, tobacco and other drugs; reduce the misuse of alcohol, tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community. Harm reduction seeks to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs. The aim of supply reduction is to prevent, stop, disrupt or otherwise reduce the supply of illegal drugs; and to control, manage and/or regulate the availability of legal drugs. Developing and implementing interventions consistent with the three pillars will contribute to closer engagement with the themes and objectives of the National Drug Strategy.

2.1 Legislative Frameworks

- *Alcohol Harm Reduction Act 2017 (NT)*
- *Gaming Control Act 2017 (NT)*
- *Gaming Machine Act 2018 (NT)*
- *Liquor Act 2018 (NT)*
- *Misuse of Drugs Act 2017 (NT)*
- *Stronger Futures in the Northern Territory Act 2012 (Cth) Part 2 Tackling Alcohol Abuse*
- *Tobacco Control Act 2016 (NT) [Note: from 2019*
- *Totaliser Licensing and Regulation Act 2016 (NT)*
- *Volatile Substance Abuse Prevention Act 2017 (NT)*

2.2 Harm Minimisation Frameworks

- Alcohol Harm Minimisation Action Plan 2018-2019 https://alcoholreform.nt.gov.au/
- Tackling Ice in the NT https://breaktheice.nt.gov.au/tackling-ice
- Darwin City Council Safe Sharps Disposal
- Local Government strategies in each Region
- Regional centre and remote community Alcohol Management Plans

2.3 Examples of Harm Minimisation Initiatives

2.3.1 Volatile Substance Abuse Prevention Act

The Northern Territory Volatile Substance Abuse Prevention Act (the Act) was introduced In February 2006, and came into force in 2010. It provides a contemporary example of harm reduction legislation. It does not criminalise VSA, and does not impose prison sentences. Its main focus is the protection, health and safety of children and adults who are abusing such substances. The Act provides police with the powers they need to address volatile substance abuse, courts with the tools they need to provide treatment to people at risk, and communities the support they need to control volatile substances and protect children and adults from the detrimental effects of volatile substance abuse.

2.3.2 Opioid Pharmacotherapy Program (OPP)

The NT OPP was established in 2002 with current service provision delivered by the Top End Health Service Mental Health Alcohol and Other Drugs Program in Darwin from a facility at the Royal Darwin Hospital (RDH) and in Alice Springs through the Alcohol and Other Drug Services Central Australia (ADSCA) at Alice Springs Hospital (ASH). There is a prison in-reach program operating in Darwin. Support is provided for dosing in Katherine. Outreach or mobile OPP services, or access via the Aboriginal Medical Services (AMSs) or Aboriginal Community Controlled Health Organisations (ACCHOs) is not currently available.

The OPP also works in partnership with community pharmacies and general practitioners (GPs) where clients are referred for their pharmacotherapy after a qualifying period. Pharmacotherapies currently utilised in the NT OPP include: methadone hydrochloride (methadone); buprenorphine; and buprenorphine and naloxone in combination (buprenorphine/naloxone) commonly referred to as Suboxone. A 2013 Review of the OPP is Attachment 1.

2.3.3 Tackling Ice in the NT

https://breaktheice.nt.gov.au/__data/assets/pdf_file/0007/231919/tackling-ice-in-nt-action-plan.pdf

(Attachment 2 Tackling Ice in the NT)

Further actions taken included:

- Education targeted at young people in school and community settings;
- Increased enforcement via Operation NEMESIS focussing on Ice manufacture and transport methods, with enhanced search and seizure powers under the Misuse of Drugs Act (NT).
- Bans on Ice pipes,
- Trialling the Hawaiian HOPE program which evolved into the NT COMMIT (Dept. Attorney General and Justice) pilot for offenders with suspended sentences to be intensely supervised via Community Corrections. This pilot operated from June 2016 for 12 months and was funded within existing resources.
- Establishment of an ‘Ice’ website https://breaktheice.nt.gov.au/

2.3.4 Needle and Syringe Programs

The Northern Territory Needle and Syringe Program (NSP) is part of the Harm Reduction pillar of Australia's National Drug Strategy. The NSP aims to prevent the spread of blood borne viruses (BBVs) such as HIV, Hepatitis B and C, and reduce the harms association with injecting drug use. The Northern Territory AIDS and Hepatitis Council (NTAHC) operates three NSPs in the NT – Darwin, Palmerston and Alice Springs. Continuation of stabilised Needle and Syringe Programs funding is vital to maintain low infection levels.

The NT NSP continues to provide information and referrals to a range of health and social services to clients including mental health services, general practitioners, and other alcohol and drug services such as detoxification and pharmacotherapy services. Inappropriately discarded used injecting equipment is not a significant issue in the Northern Territory. Efforts of services to educate clients about appropriate disposal of used injecting equipment therefore appear to be effective.

The NT NSP has numerous strengths including well-linked cohesive and supportive services, with an experienced workforce providing critical linkages from the NSP sector with a range of other agencies and organisations. Information and education on issues relating to injecting drug use and health, referrals to other health and social services, as well as support is available from NSP services. These services also contribute to public amenity by providing facilities for the appropriate disposal of used injecting equipment and have long been regarded as a key response to minimising harm and associated costs to the Australian community.

The 2011 *Review of the Needle and Syringe Program in the Northern Territory: Report for the Department of Health and Families* is Attachment 3.

2.4 National Frameworks with NT applicability

- National Drug Strategy www.**nationaldrugstrategy**.gov.
- National Alcohol Strategy 2018-2026 (Draft) http://www.health.gov.au/internet/ main / publishing .nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/Consultation%20Draft%20National %20Alcohol%20Strategy%202018-2026.pdf
- National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014-2019
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 https://pmc.gov.au /resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23
- Effective Strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islanders people https://www.aihw.gov.au/getmedia /6d50a4d2-d4da-4c53- 8aeb-9ec22 b856dc 5/ctgc-ip12-4nov2014.pdf.aspx?inline=true

3 Type of data available from NT Department of Health that is not collected through the National Drug Strategy Household Survey, the Ecstasy and Related Drugs Reporting System or the Illicit Drug Reporting System

The Department of Health collects a range of data from government and non-government organisation (NGO) providers, including NT hospitals, Sobering Up Shelters (SUS) and specialist Alcohol and Other Drugs Services (AODS).

Person level data is collected using dedicated electronic systems that can be queried for different purposes. These include:

- CareSys – collects Hospital data
- The Sobering Up Shelter System – an online data entry portal for Sobering Up Shelter staff
- The External Service Provider Client System – an online data entry portal for NGO AODTS staff
- Community Care Information System – a proprietary database for NTG AOD services.

AOD services collect case and episode level data from all clients in specialist non-government and government AOD services as well as those seeking treatment at public hospitals and health centres.

This data is complemented by figures on drug related crime including assaults, property crime, drink driving and arrest rates.

Possible relevant summary reports include:

- Alcohol-related Emergency Department presentations
- Sobering Up Shelter admissions
- Specialist Alcohol and Other Drugs Treatment Services episodes of care.

Drug use impacts on young people

- Cannabis use among Territorians aged 14 and over remains a significant concern with 17.1% reporting use in the past twelve months compared with a National rate of 10.2%
- More than 1 in 5 (22%) Territorians aged 14 or over had used an illegal drug in the last 12 months - almost 50% higher than the national average

Treatment covers all substances and types

- 65% of all treatment relates to alcohol misuse
- Treatment for methamphetamine rose from 90 in 2013-14 to 245 in 2014-15
- The main type of treatment is counselling, followed by rehabilitation and withdrawal.

Table 1 summarises the results of the 2016 National Drugs Strategy Household Survey for the NT and Australia, with comparison to 2013 and 2010.

Alcohol is the main drug used in the NT, showing a decline between 2010 and 2016.

The proportion of the NT population using illicit drugs has been stable over the period shown, at around 18% when excluding pharmaceuticals and 22% when including pharmaceuticals.

These proportions are also consistently higher than found nationally.

The main illicit drugs reported in the NT are: cannabis (16% in 2016), ecstasy (3%) and pharmaceuticals (5%).

Other illicit drugs, such as methamphetamine, are reported in the NT, but with error rates that make the proportions unreliable.

Recent tobacco use shows similar proportions to overall illicit drug use and is consistently higher than the national result, although the proportion of daily smokers has declined between 2010 and 2013 in parallel with the national proportions.

The reported pattern of illicit drug use suggests that the NT has relatively high proportions of cannabis and ecstasy use, but a less diverse range of other illicit drug use.

Table 1: Summary of recent[a] drug use, people aged 14 years or older, by state/territory, 2010 to 2016 (per cent)

	NT			Australia		
Risk status	**2010**	**2013**	**2016**	**2010**	**2013**	**2016**
Current smoker	26.0	24.2	20.9	18.1	15.8	14.9
Recent drinker	86.3	83.6	76.9#	80.5	78.2	77.5
Illicit (excluding pharmaceuticals)						
Cannabis	16.5	17.1	16.0	10.3	10.2	10.4
Ecstasy[b]	3.2	3.7	2.9	3.0	2.5	2.2
Meth/amphetamine[c]	*2.1	*2.8	*1.4	2.1	2.1	1.4#
Cocaine	**0.5	*2.4	*2.5	2.1	2.1	2.5
Hallucinogens	*2.6	*1.8	*1.3	1.4	1.3	1.0#
Inhalants	*1.5	*0.8	*0.7	0.6	0.8	1.0
Heroin	n.p.	n.p.	**<0.1	0.2	0.1	0.2
Ketamine	n.p.	**0.4	n.p.	0.2	0.3	0.4
GHB	n.p.	n.p.	n.p.	0.1	*<0.1	*0.1
Synthetic Cannabinoids	n.a	2.8	**0.3#	n.a	1.2	0.3#
New and Emerging Psychoactive Substances	n.a	*0.6	*0.9	n.a	0.4	0.3
Injected drugs	**0.6	*0.3	*0.4	0.4	0.3	0.3
Any illicit[d] excluding pharmaceuticals	18.8	19.0	18.0	12.0	12.0	12.6
Pharmaceuticals						
Pain-killers/analgesics and opioids[c] (includes OTC[e])	4.0	4.1	n.a	3.3	3.5	n.a
Pain-killers/analgesics and opioids[c] (excludes OTC[e])	n.a	2.6	4.2	n.a	2.3	3.6
Tranquillisers/sleeping pills[c]	*1.2	1.8	*1.8	1.5	1.6	1.6
Steroids[c]	n.p.	**0.1	**0.3	0.1	*0.1	*0.1
Methadone or Buprenorphine[c]	**0.1	**0.1	**<0.1	0.2	0.2	0.1
Misuse of pharmaceuticals[f] (includes OTC[e])	4.5	5.2	n.a	4.2	4.7	n.a
Misuse of pharmaceuticals[f] (excludes OTC[e])	n.a	3.8	5.1	n.a	3.6	4.8
Any illicit[f]	21.3	22.0	21.6	14.7	15.0	15.6
None of the above	11.6	12.6	19.0#	16.6	18.5	19.5

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
** Estimate has a high level of sampling error (relative standard error of 51% to 90%), meaning that it is unsuitable for most uses.
# Statistically significant change between 2013 and 2016.
n.p. not published because of small numbers, confidentiality or other concerns about the quality of the data.
(a) Used in the previous 12 months. For tobacco and alcohol, recent/current use means daily, weekly and less than weekly smokers and drinkers.
(b) Included 'designer drugs' before 2004.
(c) For non-medical purposes.
(d) Illicit use of at least 1 of 12 drugs (excluding pharmaceuticals) in the previous 12 months in 2013. The number and type of drug used varied between 1993 and 2013.
(e) OTC refers to paracetamol, aspirin and other non-opioid over-the-counter pain-killers/analgesics (see *Note* for more details).
(f) Used at least 1 of 16 illicit drugs in 2016 - the number and type of illicit drug used varied between 1998 and 2016.
Note: For years 2001 to 2010, 'Pain-killers/analgesics and opioids' refers to the combined rates from the 'pain-killer/analgesics' and 'other opiates' sections and may include the use of non-opioid over-the-counter (OTC) drugs such as paracetamol and aspirin.

In 2013, a new question was added to the survey and captured the types of prescription and over-the-counter analgesics used allowing the 2013 data to be reanalysed including and excluding non-opioid over-the-counter drugs such as paracetamol and aspirin. In 2016, pain-killer/analgesics and opioids sections were combined into one section and references and questions about use of non-opioid over-the-counter (OTC) drugs such as paracetamol and aspirin were removed.
While analyses have been undertaken to make the 2013 and 2016 data as comparable as possible, the changes to the 2016 survey has resulted in a break in the time-series for pain-killers and opiates and also for the overall misuse of pharmaceuticals. As the data are no longer comparable, significance testing was not undertaken between 2013 and 2016 for 'pain-killers/analgesics and opioids' or misuse of any pharmaceutical.
Source: NDSHS 2016

Table 2 shows the drug injected most often in the past month by a sentinel sample of 100 injecting drug users in the NT, compared to a national sample of 888. While these results are indicative and cannot be generalised to the entire illicit drug using population, they show that heroin use is rare in the NT compared to Australia as a whole and that pharmaceutical morphine use is almost five times the national proportion.

Table 2: Drug injected most often in the last month, NT and National, sentinel sample.

	National	NT
Heroin	39	1
Methamphetamine	40	33
Speed	*3*	*9*
Base	*1*	*0*
Crystal	*36*	*24*
Morphine	12	58
Oxycodone	1	2
Methadone	5	2
Buprenorphine	3	1
Cocaine	<1	0
Other drugs	0	2

Source: IDRS

Table 3 shows the proportions reporting recent speed powder and crystal methamphetamine use among the same sampling frames over time. This table shows the decline in speed powder use and the increase in crystal use seen both nationally and in the NT. Figure 1 suggests that the rate of increase in crystal methamphetamine use in the NT accelerated between 2014 and 2016, reaching similar levels as seen nationally.

The information available from wastewater monitoring is limited in the NT case due to inconsistent monitoring over time across a small and varying number of sites. Available results do, however, support the patterns described, with methamphetamine use being similar to national levels, ecstasy use being higher than national average and heroin use being rare. The results also suggest that the use of these drug types is lower in regional areas than in the Capital city.

Table 3: Drug injected most often in the last month, NT and National, sentinel sample.

	Speed powder		Crystal	
	National	NT	National	NT
2004	53	60	52	32
2005	60	69	43	21
2006	56	57	57	29
2007	55	58	46	29
2008	48	50	49	28
2009	48	50	37	15
2010	41	25	39	18
2011	44	43	45	28
2012	40	46	54	26
2013	34	31	55	30
2014	30	16	61	26
2015	25	25	67	60
2016	20	24	73	69
2017	20	19	68	60

Figure 1: Recent crystal methamphetamine use among sentinel samples, 2004 to 2017, NT and national.

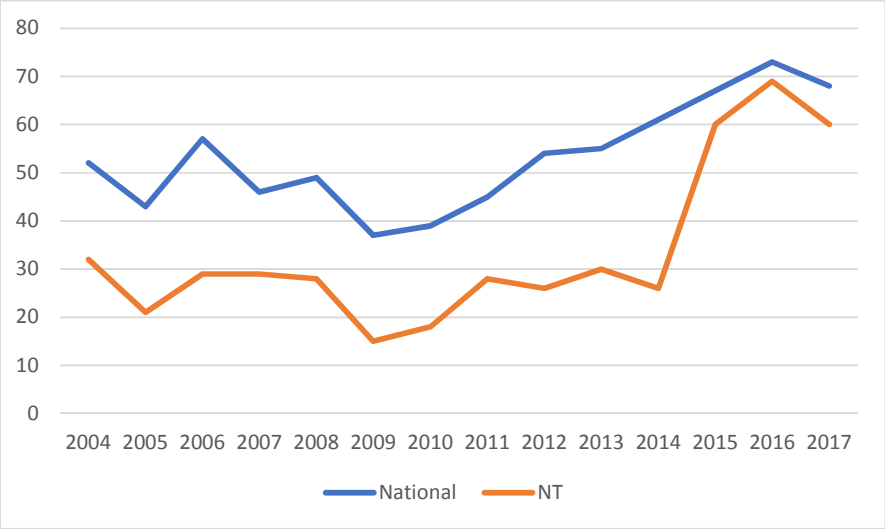

Table 4 summarises commencements in NT AOD treatment services by Health Service and principal drug of concern (PDOC) from 2015/16 to 2017/18. It shows that while alcohol is the most commonly reported PDOC across both regions, TEHS sees comparatively more episodes involving illicit drug use: amphetamines (including methamphetamines), cannabis and opioids; while CAHS sees proportionally more episodes involving alcohol.

In 2016/17, the most recent national comparison year available, alcohol was the PDOC in 32% of all AOD treatment service episodes in Australia, cannabis in 22% and amphetamines (including methamphetamines) in 26%. Opioids were the PDOC in approximately 3% of episodes nationally in that year.

Note that treatment seeking behaviour does not necessarily reflect drug use patterns, prevalence or availability and is influenced by factors such as the types of treatment available, treatment service capacity and perceptions of treatment effectiveness.

Table 4: Treatment episodes commenced in AOD treatment services, by principal drug of concern, by Health Service, 2015/16 to 2017/18

	2015/16	2016/17	2017/18
TEHS	n=3522	n=3395	n=3800
Alcohol	44%	46%	46%
Amphetamines	16%	18%	17%
Cannabis	23%	22%	21%
Opioids	6%	4%	4%
Volatiles	9%	8%	10%
Other	2%	2%	2%
CAHS	n=2248	n=2179	n=2290
Alcohol	65%	76%	74%
Amphetamines	7%	7%	8%
Cannabis	12%	10%	9%
Opioids	0%	0%	1%
Volatiles	13%	7%	6%
Other	3%	1%	1%
NT	n=5770	n=5574	n=6090
Alcohol	52%	58%	57%
Amphetamines	12%	14%	14%
Cannabis	18%	17%	16%
Opioids	4%	3%	3%
Volatiles	10%	7%	9%
Other	3%	1%	2%

4 Provision of NT and Commonwealth funded Alcohol and Other Drug (AOD) treatment services for adults and juveniles in urban, regional and remote areas.

The Department of Health funds a range of services across the Northern Territory to provide withdrawal, treatment and therapeutic support for a range of substances including a mix of residential rehabilitation, outpatient and outreach services. Current treatment services focus primarily on counselling, drug education, harm reduction approaches, and supporting withdrawal and relapse prevention.

Funding is provided to specialist government AOD services in Top End Health Service and Central Australia Health Service, and to NGOs

Alcohol is still the main substance of choice for treatment in the Northern Territory (57.5%) followed by Cannabis (15.5%) and Methamphetamine (10.0%).

Table 5 - AOD Treatment Services

AOD Service Type	Numbers of Services	Beds
Sobering up Shelters	5	96
Adult Residential	10	225[1]
Youth Residential	4	30
Continuing Care Coordination (Aftercare)	5	N/A

Table 5.1

DARWIN REGION		
AOD Service	Beds	Funding
Banyan House	24	1 087 315
Council for Aboriginal Alcohol Program Services (CAAPS) *VSA specialist for 10-25yr olds	10	791 532
Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD)	16	1 083 174
Mission Australia (Stringybark)	40	2 550 000
Salvation Army	25	1 190 540
Darwin Sobering up Shelter – Mission Australia	40	959 265
KATHERINE REGION		
Kalano - Venndale	20	567 095
Katherine Sobering up Shelter – Mission Australia	18	617 660
BARKLY REGION		
Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG)	20	982 821
Tennant Creek Sobering up Shelter - BRADAAG	16	608 068
CENTRAL AUSTRALIA		
Bushmob *VSA specialist for 10-25yr olds	20	1 301 620
Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU)	14	1 090 464
Drug and Alcohol Services Australia (DASA)	20	1 167 080
Alice Springs Sobering up Shelter – (DASA)	16	889 614
NHULUNBUY		
Nhulunbuy Sobering up Shelter – East Arnhem Regional Council	6	369 100

[1] 170 Beds NTG funded with overall average 225 beds (maximum 229) including PMC and Dept. Corrections etc. funded across 10 Residential Programs

Table 6 - Treatment episodes

AOD Services 17/18 FY	Numbers
AOD Assessments	4,510
AOD Therapeutic services (youth and adults)	2,166
Sobering-Up-Shelter admissions (adults)	10,479
AOD Residential episodes (adults)	895

4.1 Adult Sobering Up Shelters

The Sobering Up Shelters (SUS) provide support, care, treatment and monitoring for people over the age of 18 years who are intoxicated from alcohol and other drugs in a safe environment while they sober up. Prior to discharge clients undergo an AUDIT Tool assessment, a brief intervention and are offered the opportunity to be referred to other services for ongoing support and treatment to address their alcohol and other drugs issues. SUS are funded by the Northern Territory Government and are gazetted as places of safety under the Volatile Substance Abuse Prevention Act. A 2013 *Review of NT Sobering Up Shelters* is Attachment 4.

Shelter	Beds	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Alice Springs	16	205	184	166	253	219	315	336	298	354
Darwin	40	331	410	405	430	464	449	440	521	490
Katherine	18	31	38	20	50	44	52	47	64	70
Nhulunbuy	6	3	2	7	4	16	32	17	9	1
Tennant Creek	16	47	55	79	131	184	138	123	169	209
Total		**617**	**689**	**677**	**868**	**927**	**986**	**963**	**1,061**	**1,124**

4.2 Adult Residential Programs

Residential treatment services deliver evidence based, structured programs of rehabilitation for clients affected by drug, alcohol and/or volatile substances over an identified timeframe. The programs include developing an achievable, goal orientated plan for each client, in consultation with the client and/or family or significant others on admission. The table below shows % occupancy rates per month.

Region	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Alice Springs	47	53	76	91	88	76	78	81	86
Darwin	64	53	53	53	64	70	71	67	66
Katherine	105	78	50	27	47	69	90	81	58
Tennant Creek	90	115	80	97	97	96	95	94	112
All NT	69	64	65	68	76	78	83	81	79

4.3 Youth AOD Services

Youth Residential Rehabilitation treatment programs deliver structured services that are evidence based and culturally appropriate to clients aged 10 to 25 years affected by volatile substances, drug and/or alcohol abuse and misuse. The 24 hour 7 day per week fully supervised residential rehabilitation program includes developing an achievable, goal orientated plan for each client, in consultation with the client and/or family, VSA Clinical Services or significant others on admission.

Clients' progress against the plan and the clear expectations of the program are regularly reviewed and the individual plan will be adjusted as required, throughout the treatment period. Education, vocational and cultural programs are provided with the aim at improving the life situation and outcomes for disadvantage and disengaged young people of the Northern Territory through participation in capacity and resilience building activities as part of this program.

Holyoake - Trauma Informed Care Service

Provides trauma specific therapeutic interventions to individuals, families and/or groups throughout Alice Springs supporting recovery from trauma through fostering engagement, establishing safety, provision of psychoeducation, improving distress tolerance skills, strengthening social connectedness, providing trauma specific interventions and relapse prevention strategies to individuals and their families.

This service provides training, ongoing professional development and supervision to staff to improve service awareness of trauma informed care principles and enable a trauma informed view of presenting behaviours across the organisation. The program will include developing an achievable, goal orientated Individual Management Plan (IMP) for each client, and where appropriate in consultation with the client and/or family or significant others on assessment. The service is now in its 2nd year.

4.4 Individual Support Programs, Alice Springs and Katherine

Katherine Individual Support Program (KISP)

This culturally secure program supports a range of pathways to ensure wrap-around service delivery for Aboriginal people adversely impacted by AOD use in the Katherine region. The programs work across a range of agencies including Aboriginal community controlled Health organisations. Programs include Collaborative Case Management, Wellness Support Program via Katherine Hospital, Social and Emotional Wellbeing assessments and referrals, facilitated income support, employment readiness and training and a Return to Country Program. This is supported by inbuilt evaluation and research, agency coordination, agency partnership brokerage and staff professional development.

Tangentyere Individual Support Program (TISP)

Similarly to KISP, this culturally secure program supports a range of pathways to ensure wrap-around service delivery for Aboriginal people adversely impacted by AOD use in the Alice Springs region and the Town Camps. The programs work across a range of agencies including Tangentyere Council and Aboriginal community controlled Health organisations. Programs include Early Intervention and Family Support, Assertive Outreach and Case Management, Return to Country Program, Facilitation of self-help groups, community member developed Community Information materials, Pre employment support and training, with in-built Participatory Action Research and Evaluation.

4.5 Continuing Care Coordination ('CCC' AOD Aftercare)

These services are funded through the National Partnership Agreement on Remote Aboriginal Investment, Community Safety Implementation Plan Initiative.

Table 7- Continuing Care Coordination

Region	Organisation	Dates operating
Central Australia	CAAC -Congress	2016 - ongoing
Katherine	Kalano Community Association	Late 2017 - ongoing
Barkly	BRADAAG	Late 2017 - ongoing
Top End	FORWAARD	April 2018 – ongoing
	Danila Dilba	July 2018 - ongoing
Discontinued services	Saltbush Mob	2016 -September 2017
	St Vincent de Paul	Late 2017 – July 2018

Support is provided in the community for up to six months after discharge from treatment for the primary purpose of relapse prevention to enable clients to change their drinking behaviour and achieve pathways to recovery.

The Continuing Care Coordination (CCC) model works on a hub and spoke model with specialist clinicians and case managers in the hub providing case management and specialist support and coordination, to not only clients but also their community supports. CCC also provides linkages with primary health care workers, the remote AOD workforce, legal practitioners, and people working on the ground providing individual client treatment and support to people returning to communities post rehabilitation.

The CCC model is provided in the community, and is aimed at strengthening pathways to recovery and preventing relapse following discharge from rehabilitation or other AOD treatment. New expanded pathways are developed for people with AOD issues to access treatment services. Services build on these treatment pathways by providing a sustainable model for continuing care in regional and remote communities. The model provides strong links with primary health care and the local remote AOD workforce in each community.

As of 29/8/2018,

- there were 1,412 treatment episodes for 1,205 individuals where the main treatment type was rehabilitation and the date of cessation was between 1/7/2017 and 29/8/2018 or the episode was still open;
- there were 323 episodes for 295 clients where the service type was aftercare and the date of cessation was between 1/7/2017 and 29/8/2018 or the episode was still open;
- there were 144 clients where they had had at least one episode where the main treatment type was rehabilitation and at least one episode where the service type was aftercare.

Out of the 1205 individuals who had a rehab episodes, 87% had one episode and 13% had 2 or more, average of 1.2 per person. Out of the 295 individuals who had a service type of aftercare, 92% had 1 and 8% had 2 or more, an average of 1.1 per person.

4.6 Counselling, Information and Education Providers

(Seven AOD Counselling services plus Quitline [tobacco])

Structured programs of counselling interventions to individuals and their families using evidence based best practice. Programs include developing achievable, goal orientated Individual Management Plans (IMP) for each client, and where appropriate in consultation with the client and/or family or significant others on assessment. Family counselling is provided when identified as a part of a client's IMP. Additionally, AOD group counselling will be provided when it is identified that particular groups of individuals are facing a similar issue due to their misuse of AOD, such as health, legal and relationship issues. The group counselling is to focus on the AOD misuse issues. Planned Alcohol and other Drug

Information and Education sessions may be provided to individuals, families and groups that can focus on education, prevention, management of problems and relapse prevention requirements.

- Amity Community Services – Counselling, Information and Education, Darwin
- CAAAPU Information and Education/Outreach, Alice Springs
- CatholicCare – Information and Education – Darwin urban, Tiwi and Wadeye
- Employee Assistance Service (EASA) – Counselling, Information and Education, Darwin
- Holyoake – Counselling, Information and Education, Alice Springs
- Cancer Council SA – Quitline - telephone counselling service with a proactive call back program,
- Eastern Health (Turning Point) – Telephone Information Service - a 24 hour, seven days a week telephone information service for
    - Alcohol and Drug Information Service (ADIS) 1800 131 350 – the confidential drug and alcohol counselling, information and referral service for the general community.
    - Drug and Alcohol Clinical Advisory Service (DACAS) 1800 111 092 – telephone consultancy service for Health professionals to assist with the clinical management of drug and alcohol problems.

4.7 Youth Counselling, Information and Education Providers

Macdonnell Regional Council – Information and Education, Central Australia

MHAODB, DOH provide funding as a contribution towards one FTE Youth Engagement Officer based in Kintore. The YEO provides support to youth who are at risk of volatile substance abuse and/or alcohol and other drug abuse through the provision of living skills, educational and pre-vocational skills training. Macdonnell Regional Council are historically funded to deliver this service

Miwatj Aboriginal Health Corporation

Miwatj provide three FTE Youth VSA Workers, two based in Galiwinku and one based in Milingimbi. These workers enhance Miwatj's existing Social and Emotional and Welling program and Mental Health and AOD services through the provision of evidence based therapeutic intervention to support individuals and their families in reducing their volatile substance use in a culturally appropriate manner.

Roper Gulf Regional Council – Information and Education, Katherine region

MHAOD provide funding as a contribution towards the Roper Gulf Regional Council Community Safety Strategy. The CSS provides advice and support for people at risk of volatile substance abuse and/or alcohol and other drug abuse through the provision of diversionary, education and cultural programs. Roper Gulf Regional Council are historically funded to deliver this service.

Warlpiri (Mt Theo) – Information and Education, Central Australia

MHAOD provide funding as a contribution towards the Mt Theo Youth Development Programs. The YDP provides diversionary, therapeutic, education and cultural programs to youth. Warlpiri are historically funded to deliver this service.

4.8 Remote AOD Workforce

The Remote AOD Workforce Program is a combination of remote AOD workers in the Top End Health Service, Central Australia Health Service and Aboriginal Community Controlled Organisations in the NT. The program consists of over 50 workers across 40 communities. he role of the remote AOD worker is provide direct client and family support services in a community development model that increase the capacity for service provision at the local level, and enables appropriate support for clients, carers, families and communities affected by AOD issues. Additional information can be found at: https://remoteaod.com.au/about-us

4.9 Alcohol Action Initiatives

This program is funded through the National Partnership Agreement and works with remote communities to develop and implement individual projects to reduce alcohol and drug related harm and demand. These projects are localised and specific to the respective communities. Since 2016 the program has allocated $7,259,000 supporting 202 AAIs across 42 communities in Central Australia, Barkly, Katherine, Top End, Tiwi and Arnhem regions. Consultation and development with other communities for their 2019 AAIs is in progress.

Number of AAIs to date	Total expenditure to date	No. of communities
202	$7,259,000	42

https://health.nt.gov.au/professionals/alcohol-and-other-drugs-health-professionals/alcohol-for-health-professionals/alcohol-management-plans/alcohol-action-initiatives

Examples of projects

NAAJA Restorative Justice Project

NAAJA is delivering a 2 year restorative justice project in 5 remote communities of the Northern Territory. The project will empower Elders, communities leaders and Law and Justice groups in Maningrida, Gunbalunya, Groote Eylandt, Wadeye and the Tiwi Islands. The focus of the project is to build capacity of participants applying the 'Restorative Justice framework' who will subsequently engage young participants to address the misuse of alcohol.

Wurrumiyanga Men's Shed

The Wurrumiyanga Men's Shed was refurbished to support the Men's Healing Group that gathers each week to hunt and prepare traditional food in a positive alcohol-free environment. CatholicCareNT coordinated the refurbishment which has given men access to facilities to: prepare healthy meals; sing traditional songs; keep fit with weights and other gym equipment; and make traditional cultural artefacts like spears for hunting and arm/head bands for ceremonies. The Men's Shed is also space for men to meet and discuss their concerns in a safe environment. The refurbishment provides a popular alternative to drinking on nights when the club is open.

Borroloola Cattle Workshops

Roper Gulf Regional Council and Territory Rodeo Services delivered the Great Borroloola Cattle Workshops from 2nd to 7th October 2017. The workshops targeted young people up to the age of 24. A total of 82 participants completed the two day Rodeo program. The workshops included a range of lessons and games designed to entertain participants as they developed skills required to compete at rodeos and ultimately seek employment in the Northern Territory cattle industry.

Tiwi Island Community Harmony Areas

The Pirlangimpi Community Harmony Area Project was identified and designed by community members on the Pirlangimpi Alcohol Reference Group. The Community Harmony Areas are an alcohol demand reduction activity that creates meaningful employment and professional development opportunities for local community members, along with a greater sense of community pride for all involved. The project consisted of 3 community barbecue areas being constructed by 14 Community Development Programme (CDP) workers who completed a Certificate 2 in Construction throughout the activity. This project was a partnership between the Pirlangimpi Alcohol Reference Group, The Department of Health, Tiwi Island Training and Education Board (TITEB), The Pirlangimpi ALPA Store, The Tiwi Island Regional Council, The Batchelor Institute of Indigenous Tertiary Education and the wider community. The Community Harmony Areas caught the attention of other communities in the Tiwi's, who were keen to deliver Alcohol Action Initiatives of their own. The Community Harmony Areas are used to celebrate Mother's Day, Territory Day and other alcohol free community events.

4.10 Youth AOD Grants

Funding of $280 000 was provided for 18 local community-led information, education and diversionary activities across the Northern Territory. The successful applications demonstrated a direct correlation with the National Drug Strategy, National Ice Action Strategy and/or the National Aboriginal and Torres Strait Islander Peoples Drug Strategy.

Table 8 Youth AOD grant projects

Organisation	Project	Project Description
Top End Health Services - Remote Health - Groote Eylandt Angurugu Clinic	Engage with youth - take outstations, fishing, hunting, sport.	Alcohol and Other Drugs (AOD) worker engagement in diversionary activities with young people.
Neighbourhood Watch	Demand and Harm reduction Art Project	Art mural developed by youth in Palmerston that reflects community safety.
Ngukurr Art Aboriginal Corporation	Youth Diversion Expressive Art Project	Workshops to deliver music/Drama/Theatre. Second stage recording songs, stories in relation AOD. Music track soundscape recorded
Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council (NPY Women's Council)	Tjulpu and Walpa-two children two roads.	Developing a digital version of the book. A resource for community workers, parents, families and communities to grow strong and happy children.
Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council (NPY Women's Council)	Kulila - the Pitjantjatjara phrase for 'listen up!' The app is a customisable touch and listen language dictionary app.	Kulila – will be available on a wide range of Android smartphones and tablets in remote communities, instead of only IOS.Language dictionary aimed at young people and identifying emotions and expressiveness.
Corrugated Iron	Activate and Energise – Creative spark for a healthy life	Delivery of program to Ludmilla Primary, Bagot Community and Callistemon House (Katherine). Participation at NAIDOC Week.
Alice Springs Youth Accommodation and Support Services (ASYASS)	Move – Move your mind and body.	12 week program that is designed to inform youth about the developing brain whilst providing activities. Production of educational film.
	KG Dance Workshops	Expressive motivational Hip Hop Music and positive role model experience.
East Arnhem Regional Council	Drumbeat Workshop and Facilitation and Delivery	Training, Community Performance and Provision of Drums for Galiwinku. Documentation of workshops and public showing.
WYDAC (Mt Theo)	Youth Bush Camps	Bush camps with AOD focus and delivered in conjunction with Elders.

Organisation	Project	Project Description
Laynhapuy Homelands Aboriginal Corporation	Laynha (Female) Youth Wellbeing Camp	AOD Information and Education sessions to be delivered in the format of Wellbeing Camps.
Laynhapuy Homelands Aboriginal Corporation	Laynha (Male) Youth Wellbeing Camp	AOD Information and Education sessions to be delivered in the format of Wellbeing Camps.
Tangentyere Council Aboriginal Corporation	Tangentyere Social Circus	Development of support referral and pathway services. Engaging in activities to decrease risk of exposure to, and engaging in AOD usage on the streets.
Tangentyere Council Aboriginal Corporation	Trucking Yards Cooking (Healthy Living) Program	Program for at-risk town camp young people. Conversation around strong positive and health messages and to deepen understanding of the harmful effects of AOD use
Tangentyere Council Aboriginal Corporation	`Saturday Night 3 Brown Street' - Youth Drop-in Centre.	Specialist Youth Support Worker at Youth Drop in Centre Saturday nights.
Tangentyere Council Aboriginal Corporation	Inarlenge AOD Twilight Music program	Increase hours of operation leading to increase in engagement and access. AOD educational materials available.
BRADAAG	Rekindling the Spirit, Tennant Creek Youth	Kings Creek Station Camp with BRADAAG Aboriginal Men holding Diploma of Community Services (AOD)
Darwin Community Arts	Art me up Project	Substance misuse education components will be embedded in the design.

5 Emerging issues in treatment services for addictive behaviours and opportunities to address these

5.1 Recommendations from the Alcohol Policy and Legislation Review (Riley Review)

The extensive report contained a number of recommendations which are being implemented, or further developed. These included:-

A Demand Study for Alcohol Treatment Services

This will be conducted by Menzies School of Health Research and the National Drug and Alcohol Research Centre which will identify service gaps and inform the development of a multi-agency alcohol services plan.

Key research objectives include quantifying met and unmet alcohol treatment demand; the remote and dispersed settlement patterns impacts on accessing treatment; informing the development of an alcohol treatment services framework and defining NT alcohol treatment parameters; the effects of increased criminal justice system referrals; and identifying challenges, opportunities and effective options for establishing contextually and culturally responsive NT alcohol treatment services.

5.1.1. – Funding certainty for treatment programs of 7 year contracts

The current program of reform in grants management across all NT government departments has resulted in the extension of most funding contracts to 5 years duration. It is important that development of agreed KPIs for expected outcomes occur as part of service commissioning and also monitoring and review.

5.1.2. – NTG to work with training providers to overcome barriers to workforce training

Attracting and retaining appropriately skilled workforces, particularly in remote areas, remains an ongoing challenge. The NTPHN and AADNT have recently worked with the National Centre for Education and Training on Addiction (NCETA) to review and develop the Workforce Strategy for Alcohol and Other Drugs in the NT.

5.1.3. – Establishment of an Alcohol and Other Drugs court

The Department of Attorney General and Justice are exploring how this recommendation could be best implemented. In general terms, it is important that clinicians' time is used most effectively to provide interventions, and that referral to the currently available services for assessment and follow up would be a better use of time.

In response to the recommendations from the *Process Evaluation of the Banned Drinker Register*, the Department of Health has increased the information sessions and materials available to court personnel to ensure that they are aware of the opportunities and processes to refer people for therapeutic support. There has also been an extension of assertive outreach and follow up by AOD workers, for those who have been placed on a Banned Drinker Order.

5.1.4. – A residential managed alcohol program (MAP)

The Aboriginal Peak Organisations of the NT (APONT) has been commissioned to undertake consultations with treatment service providers and Aboriginal community organisations on the assessment of need and feasibility of trialling managed alcohol programs in high need areas of the NT. A discussion paper will be prepared to inform community consultations in early 2019.

5.1.5. – Review of Sobering Up Shelters

Sobering Up Shelter Review being conducted by PricewaterhouseCoopers Indigenous Consulting, due to be completed October 2018.

5.2 Other areas for potential enhancement

- Expand services suitable for Aboriginal and non-Aboriginal young women under 25 years of age including the cohort under 18 years of age. (*NT FASD Strategy)*
- Establishment of a Major Event AOD Risk Management framework/policy in line with the other jurisdictions in conjunction with NT Police and Licensing NT.
- Locally situated supported accommodation as well as options for youth and adults transitioning out of treatment programs. This could be resolved through increasing partnerships and initiatives with public housing providers and the provision of housing stock. An example of this is the recent Housing Accommodation Support Initiative (HASI), a partnership with Anglicare NT, CAAPS, NT Department of Health, the NT Department of Housing and Community Development and Top End Mental Health Services to support people with mental illness in public housing to sustain their tenancies and avoid becoming homeless.
- More holistic focus and support services and centres for people to attain an improved social and emotional well-being rather than limiting the focus to addiction management. This includes improving access to medical and psychological clinicians for specialised assessment and treatment.

- Day AOD programs that allow people to engage in treatment and support whilst engaging with supportive friends and family.
- Workforce initiatives and support for residential rehabilitation providers to assist clients that would not be normally be eligible for the program e.g. People with unstable mental illness, acquired brain injury, physical disabilities, self-care challenges. This may be resolved through access to the National Disability Insurance Scheme funding and supports for those who have significant disability, hospital Patient Care Assistants and funding to provide temporary care.
- Increased clinical support to residential rehabilitation providers e.g. Nursing and medical to improve medication management and comorbidity treatment
- Education programs and brief intervention training for schools, housing support services and community services staff.

6 Barriers to accessing AOD treatment services in urban, regional and remote areas and Aboriginal communities.

There is qualitative evidence that links AOD to poor mental health amongst Aboriginal and Torres Strait Islander people. Evidence is available around the prevalence of comorbidity and that mental health issues and substance use are often treated separately which can often lead to poor outcomes, hence the Aboriginal concept of health is interpreted within a social and emotional wellbeing framework. Therefore a multi-systemic approach (that is informed by community) is required that incorporates broader approaches to intervention.

Cultural factors impact on Aboriginal and Torres Strait Islander people in seeking treatment. The need to identify and find ways to reduce these barriers so that treatment can be accessed and at a much earlier stage rather than when in crisis, as family will often seek help from services for the individual particularly in cases where they have exhausted their avenues to try and deal with the issue themselves.

Interventions should be strengths based and enhance an individual's identity, connection to their culture and land. This should be grounded in the historical factors and the impact of this through past history and to date. A traditional healing model will enhance any intervention. A multi-systemic approach to treatment is a much better option as this reflects the principles of the SEWB model of health and wellbeing.

An ongoing barrier is lack of cost effective (not medical air evacuations or Police) transport arrangements for people in remote communities to access regionally based residential services. This is complicated when access to a residential family support model service is needed: a recent example is the cost of a youth, his mother and two young siblings for return travel from Tennant Creek to Darwin for family - based treatment at CAAPS 12-week Volatile Substance Misuse residential program, initial quotes for bus fares were approximately $1500.

7 Culturally appropriate treatment services.

Treatment and aftercare, with the client's consent should include the family so that can best support them and understand the individual's situation. Families and community may also need assistance is supporting the individual.

Aboriginal Medical Services are best placed to deliver treatment and accordingly, these services need to be adequately supported to be able to link people to specialist AOD services to provide a seamless pathway for specialist treatment.

AOD interventions with Aboriginal people need to be delivered in the context of social and emotional wellbeing (SEWB). Aboriginal people whose SEWB health is jeopardised are less likely to participate in brief intervention strategies, education, and employment.

SEWB can be affected by the social determinants of health i.e. inadequate or lack of housing, unemployment, AOD use, dislocation, racism and discrimination. Measuring treatment outcomes should reflect the SEWB model i.e. reconnection with family and community, involvement with legal system.

Mainstream interventions have been found to be less effective with Aboriginal and Torres Strait Islander people. Interventions need to incorporate family and community based, aspects of spirituality, cultural values and beliefs.

If a mainstream evidenced based intervention is going to be used then we need to adapt this so that it is culturally appropriate. This may include an integration of mainstream and traditional healing practices (and respecting these cultural differences).

Consider establishment of an Aboriginal informed panel to have input into culturally appropriate tools and treatment models.

8 Interface between AOD treatment services and mental health treatment services

The treatment of patients with dual disorders, mental illness and substance misuse disorders is a clinical challenge, as well as a systems challenge, requiring innovation and coordination. Profiles of patients with dual disorders demonstrate that they are more or differently disabled and require more services than patients with a single disorder. They have higher rates of homelessness and legal and medical problems. They have more frequent and longer hospitalisations and higher acute care access rates. For example, among patients with schizophrenia, episodes of violence and suicide are twice as likely to occur among those who abuse street drugs as among those who do not.

Treatment and social needs of patients with dual disorders differ depending on the type and severity of the disorders. Patients with dual disorders are generally less able to navigate between, engage in, and remain engaged in treatment services. Focusing on linkages highlights the fact that treatment providers, rather than patients and their families, have the responsibility for coordinating diverse and often conflicting treatment services.

Treatment must be suited to patients' personal needs and characteristics, linking services across several different systems of care. Instead of blaming patients for poor treatment outcomes as they fall through the cracks of separate service systems, patients can be empowered and better treated when given effective options. In order to work effectively together, AOD treatment providers and mental health professionals need to understand and respect the different historical and philosophical underpinnings of both systems

https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis

9 Drug education programs

All NT schools have a drug and alcohol policy and drug and alcohol awareness education however it is not always necessarily delivered or embedded in the curriculum.

https://education.nt.gov.au/education/policies/health-of-students/drugs-in-schools

https://nt.gov.au/learning/primary-and-secondary-students/health-and-wellbeing-of-students/student-health

https://nt.gov.au/learning/primary-and-secondary-students/health-and-wellbeing-of-students/student-health

Barriers to delivery, particularly in remote areas include teacher capacity, training and ability to manage the curriculum with varying school attendance, challenging student behaviours, academic levels and English not as a first language issues.

The P.A.R.T.Y. Program (Preventing Alcohol Related Trauma in Youth)

The Alcohol Policy and Legislative Review (the 'Riley Review') recommended the PARTY program be operated and expanded through Royal Darwin Hospital (RDH). This program runs in a number of jurisdictions across Australia and is licensed via PARTY Headquarters in Canada.

The purpose of the program is to provide useful, relevant information to young people about injury (trauma) that will enable participants to recognise potential injury producing situations, make informed prevention choices and adopt behaviours and actions that minimize risk.

The PARTY program has particular purpose and relevance to the Northern Territory, where alcohol related injury morbidity and mortality figures are stark in comparison to other Australian jurisdictions. The NCCTRC funded an initial pilot program in RDH until 29 June 2018. This program has proved very popular with schools in the region and is fully booked until the end of 2018. This program will be extended to both Alice Springs and Katherine Hospitals in an outreach model. It is expected that over 200 young people will have the opportunity to participate in the program every 12 months.

10 Reviews and evaluations of programs to reduce harms from addictive behaviours

- Alcohol Mandatory Treatment Evaluation https://digitallibrary.health.nt.gov.au /prodjspui/ bitstream/10137/1226/1/Alcohol%20Mandatory%20Treatment%20Evaluation%20Report.pdf
- Banned Drinker Register process evaluation https://www.menzies.edu.au/content/ Document/ BDR%20Process%20Evaluation_FINAL_28_06_2018.pdf
- Implementation and outcomes of the revised Katherine Alcohol Management Plan: an evaluation http://katherineamp.com/images/160628 _Amended_KAMP_ Evaluation _report_revisions_accepted.pdf
- Liquor permits as a measure for controlling alcohol problems: a literature review and Final Report https://www.scimex.org/newsfeed/report-urges-simpler-liquor-permit-management-in-communities
- Select Committee on Actions to Prevent FASD https://parliament.nt.gov.au/ __data/assets /pdf_ file/0005/363254/Final_FASD_Report.pdf
- Sobering Up Shelter Review 2013 (Attachment 4)
- Review of the Needle and Syringe Program in the Northern Territory – ANEX- 2011 (Attachment 3)
- Review of the NT Opiate Pharmacotherapy Program (Attachment 1)

NORTHERN TERRITORY DEPARTMENT OF HEALTH

REVIEW OF THE NT OPIATE PHARMACOTHERAPY PROGRAM (OPP)

FINAL REPORT

JUNE 2013

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C

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APPENDICES

T

TABLES

A

ABBREVIATIONS

ACT	Australian Capital Territory
ADSCA	Alcohol and Other Drug Services Central Australia
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and Other Drugs
AODP	Alcohol and Other Drugs Program
CLAC	Schedule 8 and Restricted Schedule 4 Substances Clinical Advisory Committee
D&A	Drug and Alcohol
GP	General Practitioner
HIV	Human immuno-deficiency virus
HOI	Health Outcomes International
IDRS	Illicit Drug Reporting System
NDARC	National Drug and Alcohol Research Centre
NSP	Needle and Syringe Program(s)
NT	Northern Territory
NTAHC	Northern Territory AIDS and Hepatitis Council
OPP	Opiate Pharmacotherapy Program
PBS	Pharmaceutical Benefit Scheme
PWID	People who inject drugs
TADS	Tobacco, Alcohol and Other Drug Services (Darwin)

E

EXECUTIVE SUMMARY

Health Outcomes International (HOI) was appointed by the Northern Territory (NT) Department of Health (the 'Department') in September 2012 to undertake a review of the NT Opiate Pharmacotherapy Program (the 'OPP').

E.1 PURPOSE OF THIS DOCUMENT

This document marks the completion of the review. It is a synthesis of the findings obtained as a result of the methodological processes undertaken and directs the Department towards the program areas which require improvement in order to provide a better service for clients. The evidence base for the findings made is also presented through the various qualitative and quantitative analyses which have been carried out.

E.2 OVERVIEW OF KEY FINDINGS AND RECOMMENDATIONS

The key findings made in this review include the following:

E.2.1 PHILOSOPHY AND CULTURE

A key aspect of harm minimisation in alcohol and other drugs (AOD) programs is an effective harm reduction strategy of which opioid pharmacotherapy is a key component. The evidence supports that opioid pharmacotherapy programs are most effective when they address access requirements and sufficiently meet the needs and expectations of clients such that they are retained beyond 12 months. The philosophy and culture of a program is a significant contributor to the retention of clients.

All of the structural components are in place to support the delivery of a harm reduction and client centred NT OPP service. Unquestionably, in practice these philosophies are being met to some extent for a number of clients and particularly for those who are dosing at community pharmacy. However, based on consistent feedback across OPP staff and partner agencies, and from a large number of the clients consulted there is room for improvement.

There is a relatively broad perception (rightly or wrongly) that the service tends to be inflexible and punitive. We consider this perception might be related to some extent to the risk averseness of the service and a lack of appropriate mechanisms for information exchange and clarification with key partners. There are some contextual factors that contribute to this such as a lack of experienced staff, however, it appears to be broader than this.

The current review of clinical service policy, expansion of the quality system (together with staff training) and improved two-way communication between partners, are those strategies we propose as the mechanisms for addressing the perceived culture of the program.

E.2.2 Governance

The Governance arrangements for the OPP are on the whole in line with better practice. There is an appropriate Act supported by a clinical advisory committee (CLAC) to assist in informed decision making. There are an appropriate range of existing program policy and guidelines that articulate the Governance and management arrangements and additionally these are under revision to ensure they reflect better practice. Formal authorisation mechanisms are in place and central records maintained. Program monitoring and reporting is in place. There are clear lines of accountability for management of the program and the Chief Health Officer has relevant statutory functions in relation to S8 (and S4) prescribing.

Areas for improvement with respect to the Governance of the OPP clinical services include: enhancement of the quality program; pursuit of formal accreditation; comprehensive and expedient revision of the existing policies; and consideration of the impact of structural arrangement such as the parallel OPP services in Alice Springs and the transition to the two new Hospital and Health services.

E.2.3 Service Model

The service model for the NT OPP is largely in keeping with better practice principles and is similar in approach to that found in comparable jurisdictions, in particular Tasmania and South Australia.

Where the challenges lie in meeting better practice, the issues are more-so contextual, and bound by resource constraints. These include: a limited number of prescribers; dosing points that are both limited and isolated from the affected community; and developing agreed models for case management and counselling to ensure consistency and guide training.

Improvement to the service model should be facilitated by strategies that address these issues including: strategies that encourage greater involvement of GPs; supporting existing and encouraging more community pharmacists to be involved in the program; exploring various mechanisms to increase the number of and enhance access to dosing points for the clients; ensuring policy is continuously reviewed in accordance with national and other jurisdictional policy; and that staff are well versed and trained in the applicable case management and counselling models.

E.2.4 Partnerships

It is our conclusion that the partnerships between the NT OPP and key partners need to be improved in order to meet the dual purposes of enhancing access and enabling more comprehensive bio-psycho-social support. These partners include; GPs, community pharmacy, NGOs, and other Government partners.

Partnerships that will enhance the broader health and wellbeing needs of clients require significant structural and relationship attention. A number of partners have developed a poor perception of the OPP services and this likely partly relates to factors such as differing philosophies, misunderstanding about the service, and the relayed experiences of those clients they support. The lack of formal mechanisms for discussion of the program and the rationale surrounding program guidelines does not assist this situation.

Whilst there is limited use of opioids by Indigenous people particularly outside of Alice Springs and Darwin currently, it will be important to develop a partnership with the Aboriginal Medical Services Alliance of the NT (AMSANT) to remain up to date with any developments.

It is our strong recommendation that a formal mechanism be established for regular communication between the different agencies. The aim being to develop a shared understanding of the OPP program and its philosophy, role and parameters and to provide a mechanism for shared problem solving.

Consideration should be given to recommencing a previous GP/Pharmacy liaison position and expanding this to be a liaison with all key partners.

E.2.5 Resourcing

Our consultation with OPP staff noted a high degree of satisfaction with OPP managers. There was consensus that the managers had an 'open door policy' for discussion of concerns at any time. There was consistent feedback that the management supported staff wherever it was possible within the resource restraints. The vast majority of staff commented that they considered the OPP service to be the best workplace they had experienced and felt highly supported.

The lack of experienced AOD staff within the Alice Springs based Alcohol and Drug Services Central Australia (ADSCA) service, exacerbated by the small number of staff is of concern. The capacity to recruit experienced staff is shown to be limited.

Given case management and counselling are fundamental activities of the NT OPP this should be a priority development activity for those staff with limited knowledge and experience in this area. Additionally it could be offered more broadly to the AOD sector in the NT including NGO partners.

The key issues with respect to physical facilities are the TADS service not being ideal for the purposes of providing case management and counselling and the need for an electronic system for prescribing by Medical Officers.

E.3 Conclusion

It is our conclusion that with respect to the objectives established for the review of the NT OPP, the program has most of the essential components and structure to:

- Ensure the program and service model is consistent with current national and international best practice for the management of opioid dependent people;
- Ensure the program and service model is consistent with quality health standards and the legislative requirements in managing opioid dependent people;
- Ensure the program and service model as currently constructed provides the optimal likelihood for client success as defined by the treatment goals negotiated between client and service provider.

The areas for improvement predominantly lie in the areas of sufficient access (location and number of prescribers) and the partnerships with other agencies that is seriously affecting the perception of the service. The relevant AOD experience of staff in Alice Springs is limited and exacerbated by being a small team and further complicated through having parallel services operating.

E.4 Recommendations

The key recommendations are:

1. The current review of the OPP policies continue to be undertaken with the participation of staff and in reference to other jurisdictional policy. This should be attended to as a priority and be completed as expediently as possible.

2. In finalising the updated policies, it is recommended that the 'Better Practice Principles' identified in section 1.3 be considered for inclusion in the overarching policy position.

3. The OPP quality program includes the active participation of clients in service planning and review.

4. The AODP clinical services should pursue formal accreditation with an appropriate accreditation body as is currently under consideration.

5. Explicit documentation of the theory and models that underpin the case management model and the counselling approach be undertaken.

6. Given the potential loss of integration between AODP and other Government services (e.g. Mental Health) when these services transition to the two new Hospital and Health services, a clear framework for working together be established between AODP and relevant services.

7. The parallel OPP services operating in Alice Springs be consolidated within a single service.

8. A multiplier study be undertaken to further understand the comparatively low OPP participation rates in the NT.

9. Strategies be implemented to facilitate greater involvement of GPs in prescribing through:

   - strategies and support mechanisms to encourage treatment being initiated by the GP rather than the specialist service;

   - consideration of GPs prescribing Suboxone for up to 5 clients without authorisation. Given this would be a significant change, this would require considered discussion within the Department;

   - introducing the concept of the GP as a co-prescriber as is the case for Amphetamine prescribing

   - a broader topic of training entitled 'prescribing S8 drugs' or similar be offered by an appropriate individual or agency (perhaps identified by the CLAC).

10. Enhanced access to dosing be addressed through the following mechanisms:

    - Consideration be given to 'relaxing' the guidelines (timeframe in particular) for clients moving to community pharmacy dosing and/or the rules regarding bringing them back to the specialist service for dosing for non-compliance;

    - Support the potential for greater GP and Pharmacy participation through a dedicated liaison officer;

    - Explore the feasibility of Top End Mental Health services assisting with dosing on Sundays and public holidays in Darwin at TADS;

    - Exploring the potential for dosing at Palmerston by the specialist OPP service;

    - Consulting with the community pharmacies in Alice Springs individually to further understand what the barriers are to offering the service and how this might be overcome.

11. Mechanisms be established for the ongoing analysis and monitoring of the need for OPP services outside of Alice Springs and Darwin including those that might be required to meet any future need amongst Aboriginal and Torres Strait Islander people.

12. A formal mechanism be established for regular communication between the different agencies/service partners related to the OPP clinical service.

13. Re-establish a previous GP/Pharmacy liaison position and expand this to include liaison with other key partners.

14. Investment in the training of inexperienced staff in ADSCA is critical given the small team. The Department should make the training of these staff a priority based on an assessment of identified need.

15. The continued and regular involvement of the NT's only current addiction medicine specialist in the ADSCA service is considered essential.

16. A relevant and appropriate training course for case management and counselling be identified for the OPP staff and if appropriate offered to the broader AOD sector including NGOs.

17. Opportunities to undertake minor works that would support improvement to the facilities at TADS should be pursued.

18. An electronic system for prescribing should be investigated and assessed for its cost benefit.

19. AODP could give consideration to undertaking research on benchmark staffing levels for an OPP service to ensure this meets current and future client demand.

1

INTRODUCTION

The Northern Territory (NT), Department of Health (the 'Department'), appointed Health Outcomes International (HOI) in September 2012 to undertake a review of the NT Opiate Pharmacotherapy Program (OPP).

1.1 BACKGROUND

The catalyst for this review was the release of two reports; the Review of the Needle and Syringe Program (NSP) in the Northern Territory[1] and the Northern Territory Illicit Drug Reporting System Report (IDRS)[2] which were released in 2011 and 2010 respectively. In these reports, concerns were raised about the OPP by key experts who described the program as punitive, difficult to access, unfair, inflexible and needing to establish improved links with stakeholders. Accordingly, the Department instigated this review aimed at identifying where the NT OPP is consistent with recognised best practice and where there are opportunities for improvement.

1.2 REVIEW OBJECTIVES

The following objectives were established for the review:

- Ensure the program and service model is consistent with current national and international best practice for the management of opioid dependent people
- Ensure the program and service model is consistent with quality health standards and the legislative requirements in managing opioid dependent people
- Determine whether the program and service model as currently constructed provides the optimal likelihood for client success as defined by the treatment goals negotiated between client and service provider.

This final report addresses each of the above objectives and as such, identifies where the program's strengths lie and where there are opportunities for improvement, ensuring that the service delivers a high quality program which is effective and sustainable within the NT context.

[1] Voon, D., Griffiths, P. & Ryan, J. (2011). *Review of the Needle and Syringe Program in the Northern Territory: Report for the Department of Health and Families*. Melbourne: Anex.
[2] Rysavy, P. and Moon, C. (2010). *NT Drug Trends 2010, Findings from the Illicit Drug Reporting System (IDRS), Australian Drug Trends Series No. 62*, National Drug and Alcohol Research Centre (NDARC), NSW.

1.3 Better Practice OPP

In order to provide an 'evidence base' on which to identify key areas and 'standards' for the review and subsequently make an assessment of the OPP, the evaluators have: reviewed a broad range of relevant literature and policy[3,4], consulted with jurisdictional experts within Australia (Appendix A); and consulted with the steering committee established for the review (Appendix B).

The following points summarise those better practice principles that provide a framework for the conduct of the review.

Better Practice Principles

- An overarching policy statement that includes accountability at all levels.
- The broad goal of the program and culture of the service is based on reducing harm. That is, reducing the health, social and economic harms to individuals and the community arising from illicit opioid use. As a minimum: reduce an individual's illicit opioid use; reduce the risk of overdose; reduce the risk of blood borne diseases; and improve general health and social functioning, including a reduction in crime.
- The program achieves a balance between encouraging access and maintaining safety and quality. It is considered that one of the key mechanisms for achieving this is through having a service model that includes both trained GPs and specialist services.
- Formal authorisation mechanisms are in place and central records maintained. Program monitoring and reporting is in place.
- Data and information systems to assist in monitoring, evaluation, benchmarking, planning and decision-making.
- Readily available and accessible for individuals who need it. Treatment is available where there are affected communities.
- More than one single form of treatment (Buprenorphine and Methadone).
- Pharmacotherapy is part of a comprehensive treatment program, with access to counselling and other ancillary services available to all individuals. A Cochrane Review of drug treatment found that adding counselling to methadone programs added a 30% improvement to the retention in treatment which in turn produced better outcomes.
- The service complies with relevant service standards and accreditation and has continuous quality improvement processes in place. Clients are where possible, participants in the quality system.
- Relevant operational policy and procedure (e.g. unsupervised medication, methadone dilution, number of clients per prescriber, rights, responsibilities, grievance).

[3] Australian Agency for International Development 2008, *Toolkit on Governance of Opioid Agonist Medication Treatment: Methadone and Buprenorphine*
[4] Commonwealth Government 2007, *National Pharmacotherapy Policy for people dependent on opioids*

- The program includes comprehensive client assessment processes and a subsequent treatment plan that is regularly reviewed. After-care and follow up is provided.
- Clients need to have provided their informed consent.
- The program is client centred, that is, cognisant of and responsive to the individual's goals for participating in the program.
- Patients' progress and continuation of drug use in treatment should also be monitored. However, it must be remembered that such monitoring should be done for the benefit of the patient and not for the purpose of disciplinary action against the patient. For example, when a methadone patient returns a positive urine test sample, the result should be used to discuss the possible reasons for his/her continued drug use and to find solutions to these problems rather than resulting in recrimination against the patient or discontinuation of treatment.
- Maintenance of client records – standards are established for content, quality, confidentiality, security and access.
- Retention of clients in the program is a key goal, given the evidence suggests that clients who stay in treatment for a period longer than a year do better than those who are in treatment for a few weeks or a few months and that clients return to high level of standardised mortality rate on leaving treatment.
- Appropriately skilled, trained and experienced workforce. Ongoing workforce mentoring, support and supervision.
- The service refers, collaborates or partners with other services to meet bio-psycho-social needs.
- Testing for blood borne viruses and linkage to post-test interventions.

1.3.1 Review Domains

Based on the better practice principles identified above, the following review domains (key areas of research) were determined and agreed to by the review steering committee: Service Philosophy and Culture; Governance; Partnerships; Service Model; and Resourcing. The research domains are mapped to the better practice principles in Table 1.1 below.

As is identified in the table, a number of better practice principles sit in more than one domain, most notably, access and retention. This signifies that some better practice principles are influenced by the many inter-related characteristics of an opioid pharmacotherapy program.

Table 1.1: Review domains mapped to better practice principles

Domain	Characteristics
Philosophy and culture	Overarching policy statement Harm minimisation / reduction Client centred Access and Retention

Domain	Characteristics
Governance	Overarching policy statement Accountability Safety and Quality Authorisation mechanisms Program monitoring and reporting Data systems Client records
Partnerships	Partnership with GPs Partnership with Pharmacists Link with other relevant agencies
Service Model	Client centred Accessible Operational Policy Multiple treatment forms Assessment and treatment planning Adjunct services
Resourcing	Skilled and experienced workforce Workforce training and development Physical resources Funding levels

1.4 Review Methodology

The following is an outline of the methodological process which was undertaken in order to carry out the review.

Stage 1 – Project Planning. During this stage the review process was finalised and a Project Plan was submitted to guide the process of the evaluation. Key representatives from the Department and Steering Committee were consulted during a project initiation meeting, relevant documents were identified and obtained and key stakeholders who would inform the review were identified.

Stage 2 – Review Framework. The objective of this stage was to develop an agreed program logic (Appendix E) and review framework (Appendix G). The framework was informed by: the conduct of a literature scan; consultation with five jurisdictional technical experts, the review steering committee and other relevant stakeholders around better practice elements of an OPP service and the general conduct of the review; development of a program logic to provide an illustrative view of the program itself; and a review of relevant datasets.

An ethics application was also submitted and accepted by both the Top End and Central Australia Human Research Ethics Committees to undertake the fieldwork stage of the review.

Stage 3 – Fieldwork. During this stage a number of key tasks were carried out including a review of program documentation and consultations with key stakeholders, clients and potential clients (those who would benefit from the program but have elected not to participate) as listed in Appendix C.

Ethical approval was gained from the Department of Health's designated Human Research Ethics Committees (HREC) in both the Top End and Central Australia for the conduct of the client and potential client consultations. Promotion of the consultation process to clients occurred through TADS and ADSCA, NTAHC in Darwin and Alice Springs, relevant NGOs (e.g. Banyan House) and community pharmacies offering a dosing service to clients.

The findings obtained from this process were in turn analysed and synthesised, informing the development of a draft report. The review steering committee and the Department provided feedback on the draft report before production of the final report.

Stage 4 – Final Reporting. The objective of the final report was to amalgamate and analyse the feedback received throughout the review and propose to the Department where the program has strengths and where improvement in the program could be made.

1.5 Structure of This Document

The remainder of this Discussion Paper will be structured in the following manner:

Chapter 2	Provides an outline of the program itself, as well as the clients it services.
Chapter 3	Provides an outline of the key findings with respect to the philology and culture of the service.
Chapter 4	Provides an outline of the key findings with respect to the governance of the service.
Chapter 5	Provides an outline of the key findings with respect to the service model which underpins the service.
Chapter 6	Provides an outline of the key findings with respect to the partnerships which exist, or do not exist within the service and between other services.
Chapter 7	Provides an outline of the key findings with respect to resourcing issues affecting the service.

2

PROGRAM OVERVIEW

This chapter provides a background to the NT OPP, its structure and purpose and a profile of the clients it currently provides a service to.

2.1 THE NT OPIATE PHARMACOTHERAPY PROGRAM

The following section provides background to the establishment of the NT OPP and the current service delivery model. The service delivery model in particular is discussed in greater detail in chapter 5.

2.1.1 BACKGROUND

The Northern Territory has a past history of methadone treatment programs that ceased in the 1970's. Subsequently, the provision of pharmacotherapies in the NT was prohibited until changes to legislation in 2001. The NT OPP was established in 2002 in response to the Illicit Drug Taskforce recommendations to: amend the *NT Poisons and Dangerous Drug Act* that prohibited the use of Schedule 8 medications for the purpose of treating addiction; a pharmacotherapy program be provided in both the public sector, and in the private sector through the use of accredited general practitioners; and the public sector component be established as a specialist service, located in Alice Springs and Darwin, with outreach services to Palmerston.[5]

2.1.2 SERVICE DELIVERY POINTS

Current service provision is delivered by the Department of Health, Alcohol and Other Drugs Program (AODP), occurring in Darwin through the Tobacco, Alcohol and Other Drug Services (TADS) operating from a facility at the Royal Darwin Hospital (RDH) and in Alice Springs through the Alcohol and Other Drug Services Central Australia (ADSCA) located on the grounds of the Alice Springs Hospital (ASH). There is a prison in-reach program operating in Darwin. Support is provided for dosing in Katherine and the potential for dosing in Nhulunbuy has been 'proven' but not utilised as yet. No outreach or mobile OPP services are offered in the NT. No OPP service is available through the Aboriginal Medical Services (AMSs) or Aboriginal Community Controlled Health Organisations (ACCHOs).

The OPP also works in partnership with community pharmacies and general practitioners (GPs) where clients are referred for their pharmacotherapy after a qualifying period. However, the numbers of participating pharmacies and GPs are low when compared to that of other Australian jurisdictions. Accordingly, the service could be described as very much a specialist service given the comparatively low number of community based services.

[5] NT Illicit Drugs Taskforce 2001, Taskforce on Illicit Drugs Report available at http://www.health.nt.gov.au /Alcohol_and_Other_Drugs/Publications/index.aspx

2.1.3 PHARMACOTHERAPIES AND SERVICE PROVISION

As is the case in other Australian jurisdictions, the pharmacotherapies currently utilised in the NT OPP include: methadone hydrochloride (methadone); buprenorphine; and buprenorphine and naloxone in combination (buprenorphine/naloxone) commonly referred to as Suboxone.[4]

The public clinic services in the NT provide an adjunct service that includes for example, case management and counselling in addition to pharmacotherapy withdrawal and maintenance.

2.1.4 OPP CASES AND CLIENTS

It has been reported that demand for the service grew rapidly following its introduction. However, since 2007/08 the number of cases* appears to have been consistently in the range of 75-85 cases per year (Table 2.1 below) albeit there were 109 new cases opened in 2011/12.

Table 2.1: OPP Cases by financial year

Year	Open cases as at 30 June (initial year)	Cases closed by financial year	New cases opened in financial year	Open cases as at 30 June (subsequent year)
2007/08	90 (est)	89	83	82
2008/09	82	82	74	74
2009/10	74	73	71	70
2010/11	70	68	79	77
2011/12	77	55	109	87
2012/13	87			

* - n.b. a count of cases, not persons. If a person had more than one case open on June 30 for that year, then each case for the person is counted. If a client has more than one case that closed in the period, then each case will be counted separately.

Data provided by Medicines and Poisons Control section, Department of Health, NT

Of course the number of active clients at any given time may be higher, if there has been more new clients 'enrolled' comparative to the number discharged. For example, a snapshot of OPP clients provided by the Medicines and Poisons Control section on the 3rd December 2012, showed a total of 135 registered clients, with an estimated 104 in Darwin and 31 in Alice Springs based on usual location of the prescriber (Darwin may be elevated as some Darwin prescribers do relief work in Alice Springs).

However, the number of persons enrolled in the NT OPP is by Australian standards very low at 0.5 per 1,000 population (equating to approximately 116 clients). Comparatively, the Australian Capital Territory and Tasmania reported rates of 2.3 and 1.3 per 1,000 population respectively.[6] The rationale for this comparatively low participation rate is discussed throughout the report through discussion of issues relating to service ethos, access and retention.

[6] Australian Institute of Health and Welfare 2012. National Opioid Pharmacotherapy Statistics Annual Data collection: 2011 report. Cat. no. HSE 121. Canberra: AIHW.

2.1.5 CLIENTS

The following section provides a profile of the current OPP clients based on the NT Department of Health Community Care Information System (CCIS) and the 2012 National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection (a national minimum data set). A number of the client characteristics have been described using both data sources to contrast those characteristics over the life of the program with the current situation.

The Departments' CCIS data includes 338 episodes of treatment for 240 unique clients with a service type of 'Opiate Pharmacotherapy Program'. The data is based on the time period October 2002 through to the end of December 2012.

The NOPSAD data is a snapshot day relating to the 2012 year and includes 121 unique clients.

GENDER

Based on the 2012 NOPSAD data, the proportion of female to male clients is F:38% and M:62% (Table 2.2).

Table 2.2: Gender based on 2012 NOPSAD data

Female	Male	Other
38%	62%	0%

An analysis of all of unique clients in the CCIS data over the duration of the OPP illustrates the proportion of female to male clients is similar at F:40% and M:59% (Table 2.3).

Table 2.3: Gender based on CCIS data (2002-2012)

Female	Male	Other
40%	59%	0%

AGE

Based on the 2012 NOPSAD data, the greatest proportion (44%) of clients are aged between 31 and 40 years old. Seventy per cent (70%) of clients are aged between 31 and 50 years (Table 2.4). The 2012 NOPSAD data further illustrated:

- Average age of all clients is 39 years
- Average age of female clients is 37 years
- Average age of male clients is 40 years.

Table 2.4: Age based on 2012 NOPSAD data

Up to 20	21 - 30	31 -40	41 -50	51 - 60	61 - 70	N/A
0%	18%	44%	26%	12%	0%	0%

An analysis of all of unique clients in the CCIS data over the duration of the OPP, illustrates very similar proportions of clients in the 10 year age bands as illustrated in Table 2.5 below.

Table 2.5: Age based on CCIS data (2002-2012)

Up to 20	21 - 30	31 -40	41 -50	51 - 60	61 - 70	N/A
2%	27%	40%	21%	8%	0%	1%

ETHNICITY

Based on the 2012 NOPSAD data, the proportion of clients identifying as Aboriginal and Torres Strait Islander is 7% (Table 2.6).

CCIS data covering the period October 2002 through to the end of December 2012, illustrates that the proportion of clients on the OPP identifying as Aboriginal and Torres Strait Islander clients is 11% (Table 2.7).

Table 2.6: Ethnicity based on 2012 NOPSAD data

Aboriginal and Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander	Not stated
9	108	4
7%	90%	3%

Table 2.7: Ethnicity based on CCIS data (2002-2012)

Aboriginal	Aboriginal and Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander	Not stated
10%	1%	79%	10%

Our consultation with the Top End Public Health Medical Officer for the Aboriginal Medical Services Alliance of NT (AMSANT) and other key stakeholders with knowledge of Aboriginal and Torres Strait Islander health service delivery in the NT, noted that in their experience demand for opioid use was low amongst Aboriginal and Torres Strait Islander clients. This was reported to be particularly so outside of Alice Springs and Darwin.

To make a broad assessment of the participation rates of Aboriginal and Torres Strait Islander clients in the OPP, the proportion of the Darwin and Alice Springs population that identify as Aboriginal and Torres Strait Islander is provided in Table 2.8 below.

Table 2.8: Proportion of Aboriginal and Torres Strait Islander people(s) in Darwin and Alice Springs

City	Aboriginal and Torres Strait Islander population (%)
Darwin*	9.7%
Alice Springs**	18.8%

*Australian Bureau of Statistics (25 October 2007). "Darwin (Statistical Division)" *2006 Census QuickStats*.
**Australian Bureau of Statistics (25 October 2007). "Alice Springs (T) (Local Government Area)". *2006 Census QuickStats*.

This data is suggestive of reasonable participation rates in Darwin and under-representation in Alice Springs. Close partnerships with relevant Aboriginal services in both cities are critical to ensuring the services are responding to this group of clients.

Country of Birth

The vast majority of clients over the duration of the OPP (CCIS data) are born in Australia (75%) although the 'not stated' country of birth is also significant (18%) as illustrated in Table 2.9 below.

Table 2.9: Country of Birth

Australia	Not stated	All other
75%	18%	7%

Analysis of the CCIS data demonstrated that the preferred language spoken at home is English for 77.5% of clients and 'not stated' for 22.2% of clients. One person (0.3%) noted Vietnamese as their preferred language spoken at home. It appears that there is not a significant CALD community utilising the OPP and/or at least not those who may experience language barriers.

Community

The following Table 2.10 provides a breakdown of the clients recorded 'community' for the OPP overall and subsequently by the service at which they are registered. This data has been limited to include only those clients with a treatment start date in the years 2011 and 2012 to provide a current picture of the clients' designated community. It should be noted that some clients have an 'interstate' or 'other NT' community recorded but were registered with either the TADS or ADCSA service.

Table 2.10: Community recorded for All OPP clients (CCIS)

Community	No	%
Alice Springs	12	14.6%
Darwin	40	48.8%
Palmerston	17	20.7%
Other NT	7	8.5%
Interstate	6	7.3%
Total	**82**	100.0%

Table 2.11 below shows the community recorded for those clients registered with the TADS service in Darwin.

Table 2.11: Community recorded for OPP clients registered at TADS (CCIS)

Community	No	%
Alice Springs	2	2.8%
Darwin	40	55.6%
Palmerston	17	23.6%
Other NT	7	9.7%
Interstate	6	8.3%
Total	**72**	100.0%

The following Table 2.12 shows the proportion of those clients with a Darwin or Palmerston recorded community registered at TADS. It may be that those with an interstate, Alice Springs or other NT community recorded could be living in Palmerston or another part of Darwin; however, we cannot be conclusive regarding this.

This analysis is provided to be indicative only of the number and proportion of clients with Palmerston as their recorded community and potentially needing to dose at the TADS clinic in the Darwin suburb of Tiwi. It must be emphasised however, that this does not illustrate the point of dosing. That is, we cannot definitively assume that all of those with a recorded community of Palmerston are required to travel to the TADS clinic in Tiwi.

Table 2.12: Proportion of OPP clients recorded as Palmerston /Darwin (registered at TADS)

Community	No	%
Darwin	40	70.2%
Palmerston	17	29.8%
Total	57	100.0%

Table 2.13 below shows the community recorded for those clients registered with the ADSCA service in Alice Springs. All of the communities recorded are suburbs of Alice Springs.

Table 2.13: Community recorded for OPP clients registered at ADSCA (CCIS)

Community	No.	%
Alice Springs	5	50.0%
Araluen	1	10.0%
Braitling	2	20.0%
East Side	2	20.0%
Total	10	100.0%

TYPE OF ACCOMMODATION

The type of accommodation recorded for clients of the OPP (CCIS data) illustrate that the vast majority of clients (79%) live in private residences. (Table 2.14) The CCIS does not record the status of those private residences, for example, renting, purchasing or boarding with others.

Table 2.14: Accommodation Type

Private residence	Boarding/rooming house/hostel or hostel type	All Other
79%	7%	14%

2.2 Drug Use in the NT

Like any service, the NT OPP is operating within its own unique political, regulatory, legislative, clinical and environmental sphere, all of which have a significant impact on the way the service is run and the outcomes it can achieve. The following section provides contextual information in relation to drug use in the NT as reported by people who inject drugs (PWID). An August 2010 survey of PWID in the NT, noted the following key points in relation to recent use (preceding 6 months) of drugs within the NT.[2]

- In 2010 morphine surpassed cannabis as the illicit drug used by the highest proportion (91%) of the sample, with 89% reporting use of illicit morphine in this period.
- Morphine was also the drug injected most often (83% of the sample) in the last month and 78% reported morphine to be the last drug injected.
- Morphine was identified as the drug of choice by 44% of respondents. 100mg MS Contin tablets remain the form most frequently used.
- Only 5% of the sample reported recent heroin use although 71% of participants had used heroin at some time in their lives.
- Some form of methamphetamine was reported to be the drug first injected by more than half the sample (51%); however, only 7% of the sample had recently injected. Recent data from NSP indicates that methamphetamine was the most common drug injected for people accessing equipment from that service.
- Any form of methadone (including prescribed and non-prescribed methadone and prescribed and non-prescribed Physeptone) had been recently used by 35% of participants (34% in 2009).
- Any form of buprenorphine (including prescribed and non-prescribed buprenorphine and buprenorphine/naloxone) had been used by 27% of the sample (8% in 2009).
- Any form of oxycodone had been recently used by 33% of the sample (41% in 2009) and over the counter codeine (OTC) by 35% of the sample (34% in 2009).
- Recent use of any form of benzodiazepines remained high (52% in 2010 and 55% in 2009) while recent use of cocaine declined from 12% of the sample in 2009 to 4% in 2010.
- Recent hallucinogen use was reported by 4% of the sample (2% in 2009) while recent ecstasy use declined from 20% in 2009 to 10% in 2010.
- Fifty-seven per cent of participants reported recent alcohol use (50% in 2009) and 90% reported daily use of tobacco (92% in 2009).

3

PHILOSOPHY AND CULTURE

This chapter commences with a discussion of what constitutes better practice philosophy and culture for AOD programs generally and OPPs specifically. This is followed by a discussion of the overarching philosophy and culture that guides the NT OPP and how this aligns with national policy, other jurisdictional policy and other relevant better practice. It also addresses how the philosophy and culture of the NT OPP acts as a facilitator and barrier to appropriate service delivery.

3.1 HARM MINIMISATION AND REDUCTION

Since 1985 **harm minimisation** has been adopted by Australian Governments as the national framework for addressing the range of issues related to alcohol and other drugs in Australia. The National Drug Strategy (NDS) 2010 - 2015 adopts a harm minimisation approach to the use of illicit drugs and the misuse of licit drugs (including alcohol, tobacco and prescription medications). There are three aspects used when addressing AOD use through a harm minimisation approach: reducing the supply of AOD (supply reduction); reducing the demand for AOD (demand reduction); and reducing the harm from AOD (harm reduction).

Harm minimisation acknowledges that some people in societies will use AOD and therefore incorporates policies which aim to prevent or reduce AOD related harms. **Harm reduction** is a central pillar of the harm minimisation approach. This pillar aims to 'reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs'. As of March 2009 at least 84 countries worldwide supported or allowed a harm reduction approach to AOD policy.[7][8]

Part of the difficulty in defining harm reduction is that it refers to both a philosophical approach and specific types of programs or interventions. There does, however, appear to be some broad agreement and acceptance in Australia that harm reduction refers to policies and programs that are aimed at reducing AOD related harms, but not AOD use per se. A useful distinction is drawn between 'use reduction' interventions (supply and demand reduction measures) and harm reduction measures, emphasising the focus on reducing harms rather than use within the overarching harm minimisation approach.[9] The key features and principles of harm reduction include:

- respect for the human rights of people who use drugs
- the primary goal is reducing harm rather than drug use per se (focus on harms)
- it is built on evidence-based analysis (strategies need to demonstrate, on balance of probabilities, a net reduction in harm)

[7] National Centre for Education and Training on Addiction, Definition of Harm Minimisation, viewed at http://nceta.flinders.edu.au/society/harm-minimisation/, 16/5/2013
[8] Ministerial Council on Drug Strategy 2011, National Drug Strategy 2010-2015, Perth, viewed at www.nationaldrugstrategy.gov.au
[9] Ritter, A. & Cameron, J. (2005). Monograph No. 06: A systematic review of harm reduction. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre.

- should provide a comprehensive public health framework
- acceptance that drugs are a part of society and will never be eliminated
- intervention options are maximised recognising that no one prevention or treatment approach works reliably for everyone
- priority is placed on immediate and achievable goals (dependent on 'where the person is') – establishing a hierarchy of achievable interventions taken one at a time
- drug user involvement in determining the best interventions to reduce harm to themselves, others and the community
- pragmatism and humanistic values underpin harm reduction.[9,10]

The National Pharmacotherapy Policy

The current National Pharmacotherapy Policy (which is under revision) for people dependent on opioids does not explicitly describe opioid pharmacotherapy programs as a harm reduction strategy. However, the broad goal and objectives of the policy align with the definition of harm reduction stated above. The Policy's documented goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use and misuse of licit/prescribed opioids. Further it states that the objectives of pharmacotherapy treatment are to:

- bring to an end or significantly reduce an individual's illicit opioid use
- reduce the risk of overdose
- reduce the transmission of blood borne diseases
- improve general health and social functioning, including a reduction in crime. [4]

Further, the policy notes that these objectives will be achieved by engaging and retaining people dependent on opioids in treatment and that pharmacotherapies for opioid dependence should be part of a comprehensive treatment program, with access to counselling and other ancillary services available to all individuals. This emphasises the importance of access, retention and adjunct therapies and support.

3.2 Philosophy and Culture of the NT OPP

In addressing philosophy and culture there is a need to address the overarching program policy of the NT OPP and secondly how that is delivered in practice on a day by day basis. Accordingly, the first section addresses the extent to which the NT OPP philosophy and culture has been addressed in the policy of the program and the next section on the extent to which this is realised in the delivery of the service.

3.2.1 Overarching NT OPP Policy

The stated aim of the NT Alcohol and Other Drugs Program (AODP) is to **minimise harm** associated with the use of alcohol, tobacco and other drugs, through a range of prevention, education, treatment and community action initiatives.[11]

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[10] British Columbia Ministry of Health 2005, *Harm Reduction: a British Columbia community guide*, 2005, viewed at http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf

[11] Northern Territory Department of Health 2009, *Alcohol and Other Drugs,* available at http://www.health.nt.gov.au/alcohol_and_other_drugs/

Similarly, included in the Overview section of the NT OPP (revised draft) policy it is stated that the fundamental principle of the AODP is that of harm reduction. The policy further notes that the program:

- acknowledges that eradication of psychoactive substance use is not possible
- recognises the broader impact of substance use on individuals, families, social networks and communities
- supports a range of interventions
- explores treatment goals between the clinician and client (and be client led) particularly as it facilitates client retention in opioid pharmacotherapy treatment
- is based on evidence based practice that includes a combination of: evidence, clinical expertise and client values and preferences
- is set within a Mental Health Framework for Recovery-Oriented Practice
- will create an environment that supports and does not interfere with people's recovery efforts.[12]

The NT AODP and OPP policies under revision are reflective of a service that is harm reduction oriented and client centred. They purposefully align closely to the National Pharmacotherapy Policy and World Health Organisation Guidelines for pharmacotherapy. Similarly they are reflective of better practice harm reduction and opioid pharmacotherapy determined by systematic reviews and the approaches of other Australian and international jurisdictions.

Whilst referencing the policies that are under revision, we reviewed a comprehensive range of existing policy in place for the AODP broadly and the OPP specifically (variously dated between 2005 and 2007). The existing policy lacks a clear statement re the overarching policy position, however, there were references to harm reduction in various policies (e.g. Treatment Planning Policy). In finalising the updated policies, it is recommended that the Better Practice Principles identified in section 1.3 be considered for inclusion in the overarching policy position.

Given the importance of communicating a clear overarching program policy for the NT OPP, it is recommended that the revision of policies become a priority activity for the service.

Additionally, in confirming the overarching policy it will be critical to ensure that the meaning of 'Recovery-Oriented Practice' (noted as being a Mental Health Framework) be made very clear given the concern within addiction services broadly regarding the interpretation of the recovery concept. The concerns have been expressed in the literature[13] and by peak bodies including the Australian Injecting & Illicit Drug Users League (AIVL)[14].

3.2.2 PHILOSOPHY AND CULTURE IN PRACTICE

There are challenges in assessing the extent to which the philosophy and culture of an OPP is harm reduction oriented and client centred in practice. Technical aspects (e.g. the service model) are relatively easy to assess whilst the ethos and behavioural aspects such as the values, attitude and approach of staff are more difficult to assess. This section addresses both the technical and the ethos and behavioural aspects, although these are also addressed in other sections.

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12 NT Department of Health 2013, *Opioid Pharmacotherapy Program, Overview* (revised draft policies)

13 White, W 2007, Addiction recovery: Its definition and conceptual boundaries, *Journal of Substance Abuse Treatment* 33 (2007) 229–241

14 Australian Injecting & Illicit Drug Users League (AIVL) 2012, *'New Recovery', Harm Reduction & Drug Use Policy Statement*, unpublished, available from http://www.aivl.org.au/database/?q=node/17975

TECHNICAL ASPECTS

The service model is discussed more fully in chapter 5, however, the following supports the fact that the NT OPP is structured to be harm reduction oriented and client centred.

- It seems axiomatic to state that the very existence of the OPP recognises the importance of harm reduction.
- A bio-psycho-social assessment process is undertaken and an individual treatment plan developed with the client. This includes a staged process of: Induction, Stability and Maintenance.
- Pharmacotherapy options are offered to clients including buprenorphine and methadone, although the programs preferred course of pharmacotherapy is buprenorphine in the first instance. This preference was based on a recommendation of the Taskforce on Illicit Drugs premised on the attributes of buprenorphine that includes; a lower overdose risk, can be dispensed on alternate days, and offers easier withdrawal for most clients.[5] There are examples, however, of clients having their pharmacotherapy changed to suit their particular need.
- In addition to pharmacotherapy, adjunct services are delivered through a case management approach.
- Clients are assigned a case manager for the purposes of counselling and coordinating a holistic response, including referrals to other services to meet their individual needs.
- The program has operational policies (discussed above) and the *S8 and Restricted S4 Substances Policy and Clinical Practice guidelines*[15] (e.g. guideline for takeaway unsupervised doses) that provide a structure for quality service provision and management of risk.

In summary, the NT OPP is from a technical aspect structured to deliver a client centred and harm reduction oriented service.

ETHOS AND BEHAVIOURAL ASPECTS

Our assessment of the overarching ethos and behavioural aspects of the OPP have been drawn from consultations with OPP staff, OPP clients, potential clients (those persons who would benefit from the program but are not participating in the OPP) and partners or stakeholders of the OPP. The variance in feedback received from the different stakeholders consulted, appears to be largely based on the differing views and perceptions of balancing service quality against management of risk or risk assessment.

This risk assessment relates to the decisions made by the OPP concerning the management of clients in relation to their progress on the OPP. Whilst there are rules and guides to aid in the decisions regarding the management of clients (e.g. stability assessment, state of preparedness for shifting to community pharmacy, number of take-aways permitted including for specific one-off occasions and a decision to bring a client back to clinic dosing from community pharmacy), these decisions are often taken to a clinical team meeting and the final decision appears to lean more towards risk averseness for the OPP service. Some stakeholders consider this has the potential for increasing the risk to the client should they choose to subsequently leave the program. For a range of stakeholders including of course clients, these decisions are interpreted as the service being punitive and/or inflexible.

It may be that the risk assessment is influenced by contextual factors, in particular; the history of the introduction of the NT OPP, and the challenges faced by the NT in the recruitment and retention of staff, particularly highly specialist staff. These are discussed prior to a discussion of the consultation feedback.

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[15] NT Department of Health, *S8 and Restricted S4 Substances Policy and Clinical Practice guidelines, third edition* available from http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/22/11.pdf&siteID=1&str_title=S8

CONTEXTUAL FACTORS

HISTORY OF THE OPP

The introduction of the OPP in the NT has been described in some detail in Chapter 2. Whilst methadone had been used in the NT in the 1970s to treat opioid addiction this had ceased and in fact was illegal until 2002. Essentially it was a recommendation of the NT Taskforce on Illicit Drugs that saw the formalisation of the existing OPP in 2002 that included changes to the *NT Poisons and Dangerous Drugs Act,* which had prohibited the use of Schedule 8 (S8) medications for the purposes of treating addiction. The Taskforce also recommended the introduction of the Clinical Advisory Committee (CLAC) to advise the Chief Health Officer (CHO) on the prescribing of S8 drugs for opioid withdrawal and/or maintenance.

One of the terms of reference for the taskforce was to *'Advise on the particular role and practical application of pharmacotherapies within the range of interventions in the Northern Territory setting'*. However, it is our understanding based on the extended period of time where OPP was legislatively prohibited and consultations with key NT stakeholders that there had been resistance to such a service in the NT; this remained the case despite its introduction.

It may well be the case that this history of resistance to the introduction of an OPP may in fact have influenced the ethos of the service today. That is, accepting an OPP as an essential component of a comprehensive harm minimisation program, whilst adopting a risk averse approach to the delivery of the program.

STAFFING

A snapshot profile of the NT OPP staffing and their relevant experience is discussed in chapter 7. In summary, whilst there are a number of staff who have considerable OPP experience, there is a much greater number with limited experience. This is particularly the case for the ADSCA service and has been raised as a concern in other AOD reviews.[16] [17]

Additionally, the NT has until quite recently, had limited access to an addiction medicine specialist and has relied on support from the Drug and Alcohol Services South Australia (DASSA) as required. It should be noted that experienced medical officers in both Alice Springs and Darwin, who have been an integral (but scarce and fractional time resource) part of the service, are often consumed with medical assessment and reviews.

The relative lack of experienced staff may contribute to a tendency towards risk averseness. From a management perspective, enforcement and emphasis of the program rules and guidelines are important to ensure staff do not work outside their competencies. For inexperienced staff, the rules provide clarity, safety and assuredness for their practice.

Interaction between the experienced senior staff and inexperienced staff in a weekly clinical management teams and other forums should assist with increasing the understanding of risk versus quality, however, it has been reported that decisions in this forum tend to fall on the side of risk aversion.

[16] Shaw, G., MacLean, S., and Kenny, P. (2010), *Review of the Scope, Range and Effectiveness of Alcohol and Other Drug Treatment in the Alice Springs Region*, unpublished report for the NT Department of Health
[17] NT AOD Program 2009, *Proposed Clinical Service Structure, Alcohol and Other Drugs Central Australia*, Internal Discussion Paper

CONSULTATION FEEDBACK

Whilst the various groups consulted demonstrate substantial variation in feedback based on their respective perception of the quality versus risk balance, there were also some consistent views in that regard.

OPP STAFF

On the whole, OPP staff were of the view that the program policies, rules and guidelines are appropriate and provide parameters for practice. There was consensus amongst staff that the joint TADS and ADSCA weekly clinical management team meeting provided an avenue for discussion of cases where the application of policy needed consideration. They favoured a team based discussion and decision particularly where staff are inexperienced. However, a few staff (both AOD experienced and inexperienced) were of the view that generally case reviews would fall on the side of a conservative or risk averse decision although this might be contrary to the recommendation of the allocated case manager. For example, providing an additional take-away(s), progressing to community pharmacy or being brought back from community pharmacy to the public clinic despite overall good progress. In this respect, some staff hold the view that the service tends towards a greater focus on problems/issues than on progress made by the client, are inflexible in interpretation of the rules and guidelines and not rewarding of overall effort by the clients. In this regard, they are appreciative of why there would be a perception among clients that the service was punitive.

Having said this, staff also provided many examples of being flexible in their management of the clients. A number were also of the view that the team decisions are not unreasonable and are required to protect the client and the service.

PARTNERS

Government, non-government organisations (NGOs) and other sector partners (GPs, community pharmacists, Pharmacy Guild) were consulted as part of the review. Similarly to the OPP staff, there was mixed opinion regarding the ethos of the OPP.

Those working for related Government programs had mixed views of the ethos of the OPP; this was largely premised on their individual interactions with the OPP staff and clients they were involved with. There were a small number who considered the service as being appropriate with firm parameters being essential. In contrast, most were of the view that the service appeared to be more abstinence oriented, that the control lay more-so with the staff than the client and hence could be punitive in nature.

The NGOs, who are often providing other support services to a sub-group of OPP clients and appropriately are strong advocates for the clients, consider the service to be rigid and punitive. They are reaching this conclusion based primarily on feedback from a dissatisfied client sub-group, acknowledging this is likely to be a complex group of clients. This issue is in our view exacerbated by weak or non-existent relationships between some key partners. This latter point is discussed in more detail in the chapter on Partnership, however, the weakness in the relationship between the OPP and some key partners is a barrier to sharing information and having discussion around the parameters of the program and thus providing partners an opportunity to discern between essential program rules and those which might be perceived as punitive. Similarly, it may be dissuading NGOs to contact OPP personnel to obtain clarity regarding specific situations, taking into account client confidentiality. In essence there is no formal forum for differing perceptions to be challenged by factual and contextual information. This difference in perception could be enhanced by a more comprehensive case management model, discussed in chapter 5.

GPs/Pharmacists/Pharmacy Guild

Community pharmacists did not have a strong view on the ethos but did not consider the program as being necessarily rigid or punitive. This likely relates to their need for clear guidance on the management of individual clients. They noted that this is particularly an issue given their concern regarding the difficulty in contacting the specialist service for expedient decisions, particularly after hours. This issue was supported by the Pharmacy Guild as being consistent feedback they receive from their membership.

As part of the review numerous attempts were made to contact the one community based GP providing a prescribing service, but unfortunately this was unsuccessful.

Contact was made with a number of non-participating GPs who did not have a particular opinion on the ethos of the specialist OPP services.

Clients

It is widely accepted that clients in any AOD program including an OPP possess different goals for participating in a program and that these can change. Their goals can obviously be a significant factor influencing their impression of the program and their willingness to challenge those aspects they consider to be inappropriate.

As a generalisation, those clients dosing at community pharmacy were generally satisfied with the program having progressed beyond the need for daily attendance at the public clinics, while those who were dosing at the public clinics were highly dissatisfied, related to their perception of the service having strict rules, being inflexible and punitive. The limitations around the findings are the number of clients consulted, albeit 56 were consulted representing approximately 43% of the total number of clients registered (excluding prisons and private clients) with the Medicines and Poisons Control section of the Department as at the end of 2012. Their views were also consistent with the view of some staff and partners.

It is our overall assessment that in the process of balancing service quality against risk, the service leans towards being risk averse and this gives rise to a number of stakeholders and clients concluding that the service is punitive and inflexible. This is exacerbated by no formal partnership forums and poor informal relationships to share information and discuss the program rules and guidelines and provide rationale for decisions made.

3.3 Summary and Recommendations

Assessing the philosophy and culture of any AOD program is challenging as there is likely to be a variety of opinion from the different stakeholders, each influenced by their own set of values, goals, experiences and perceptions of the service.

It is our finding that the policy and program structure elements are in place to support a harm reduction and client centred approach. There is divided opinion as to the extent this is being realised in day to day practice. However, there appears to be a sufficient and consistent view from across the range of stakeholders that the program could be more flexible and client centred in its approaches that it warrants consideration.

The current review of policy, expansion of the quality system (together with staff training) and improved two-way communication between partners, are those strategies we propose as the mechanisms for addressing the perceived culture of the program.

There are a number of strategies that should be implemented, some of which are discussed in greater detail in the subsequent chapters.

OPP Operational Policies

Operational policies are often written, shelved, interpreted in daily practice and only referenced as required. The operational policies are currently being reviewed and we consider this provides an opportunity for broader input in their development.

Firstly, OPP staff should be actively engaged in their construct through the clinical management team meetings. Specifically, there should be facilitated discussion on a policy rather than distributing and asking for written or verbal feedback. Facilitated open discussion encouraging input from all levels of staff will at the very least enable discussion of factors such as values, safety, quality, and client centeredness. Whilst this will make the review and update process slower, it is considered important. Having said this, the completion of the policy revision process should be a priority given that these policies were written in the period 2005-2007.

Secondly, reference should be made to the policy of other jurisdictions, in particular Tasmania and South Australia where the program has similarities and there are existing personnel relationships. Jurisdictional policy (as opposed to National policy) is more likely to take into account the practicalities of day to day service provision. We have been advised that this is occurring.

Further, in finalising the updated policies, it is recommended that the Better Practice Principles identified in section 1.3 be considered for inclusion in the overarching policy position.

Comprehensive quality program

The introduction of a comprehensive quality program that includes more client and partner involvement should be considered. Similar to the approach to policy development, we consider this needs to be a proactive approach. That is, the process of gathering client and partner feedback should not simply rely on reacting to comments and complaints. A variety of proactive approaches could be instituted and one or more should be implemented for each of the different groups. We understand that client satisfaction surveys were introduced approximately 12 months ago and we would support their continuation and ongoing analysis of feedback. The additional forms of quality activity that might be considered include: focus groups, information and feedback sessions, and reference groups.

The AODP clinical services should also consider pursuing formal accreditation with an appropriate accreditation body. We understand that this has been planned to commence in the Darwin, Alice Springs and Nhulunbuy services in 2013. This will provide a further benchmark on which to assess the quality of the service and facilitate a process of continuous quality improvement.

Case Management/Counselling

There is detailed discussion in Chapter 5 of case management and counselling. In theory, each of these components of the service model should contribute to an ethos of harm reduction and client centeredness. For the purposes of this section, we would propose that there be explicit documentation of the theory and models that underpin these aspects for the OPP (underpinned by key features and principles of harm reduction) and that all staff be oriented and trained accordingly. This will contribute to consistency in understanding and practice in the approach to and management of the clients and service partners.

3.3.1 RECOMMENDATIONS

1. The current review of the OPP policies continue to be undertaken with the participation of staff and in reference to other jurisdictional policy. This should be attended to as a priority and be completed as expediently as possible.

2. In finalising the updated policies, it is recommended that the Better Practice Principles identified in section 1.3 be considered for inclusion in the overarching policy position.

3. The OPP quality program include the active participation of clients in service planning and review.

4. The AODP clinical services should pursue formal accreditation with an appropriate accreditation body as is currently under consideration.

5. Explicit documentation of the theory and models that underpin the case management model and the counselling approach be undertaken.

4

GOVERNANCE

This chapter assesses the Governance arrangements within the NT OPP at a number of levels including the existence of legislation, overarching governance and the governance and management at the service level.

4.1 LEGISLATION

The legislative framework for the governance of the OPP lies in the NT *Poisons and Dangerous Drugs Act*. The Schedule 8 (S8) Guidelines were amended in 2002 to enable the prescription of Schedule 8 (S8) medications for the purposes of addiction. The Act provides for the supply of S8 drugs by medical practitioners, on the basis of an authorisation by the Chief Health Officer (CHO), as advised by the Schedule 8 and Restricted Schedule 4 Substances Clinical Advisory Committee (CLAC).

4.1.1 THE S8 AND S4 CLINICAL ADVISORY COMMITTEE (CLAC)

As previously noted it was a recommendation of the Illicit Drugs Taskforce that an advisory committee with an authorisation role be introduced for the management of S8 and restricted S4 drugs. Subsequently, the CLAC was instituted and its role included advising on prescribing of S8 drugs for opioid withdrawal and/or maintenance. The advisory role of the CLAC is embedded in Part VAA of the Act. The full range of functions and powers of the committee have been included at Appendix D, however, those of particular relevance to the OPP include:

(a) to advise the CHO about the competency required by medical practitioners to supply Schedule 8 substances or restricted Schedule 4 substances

(b) to recommend to the CHO appropriate accredited training programs for medical practitioners who are to supply Schedule 8 substances or restricted Schedule 4 substances

(c) to provide expert advice to the CHO about the treatment of persons (whether generally or in relation to a particular person) with Schedule 8 substances or restricted Schedule 4 substances

(e) to make recommendations to the Minister about matters to be included in the Guidelines.

In our consultations regarding the role of the CLAC a couple of key points were raised.

Firstly, there was a view that the CLAC was an excellent mechanism for supporting the decision making of the CHO. The diverse membership brought different points of view that are considered essential for decision making in relation to policy and individual management of clients in the OPP. OPP staff and prescribers additionally found it supportive to assist them in what at times can be challenging decisions for complex situations.

On the other hand, there was an issue raised by a small number of OPP staff, an NGO commonly supporting the client group and clients concerning the capacity for the CLAC to make a decision in an expedient manner when the situation demands.

The Medicines and Poisons Control section that provides secretariat services to the CLAC, provided data relating to individual response times to requests for amendments to unsupervised doses in the 2012/13 year. Analysis of these 64 requests demonstrated that 48.4% are dealt with on the day of request, 26.6% on the following day. Ninety five per cent are responded to within 5 days. Only one request took longer than 8 days. Whilst a delay in decision making can cause distress and inconvenience for the client, it would appear that the problem is not of a magnitude that would indicate a need for changes to the current process.

4.1.2 Record keeping, monitoring and reporting

The Medicines and Poisons Control section of the Department of Health is secretariat to the CLAC and as such maintains a series of high level records (e.g. not at the client contact level) in relation to approved prescribers, applications on behalf of clients and subsequently the contract with the client. Accordingly, the Medicines and Poisons Control section can provide a definitive description of current prescribers and all of the clients on the OPP at any point in time.

Client records

Prescribers are required to complete an 'application for authority to prescribe a restricted S8 substance for the treatment of addiction' and submit the form with a photograph of the client to the Medicines and Poisons Control section.

A contract between the client, prescriber and supplying pharmacy is also required for all applications for maintenance treatments. The information provided is assessed against data held in the Drug Monitoring System database to ensure the client is not already on the OPP with an alternate prescriber. Non-standard applications are required to be submitted to the CLAC for advice before a decision can be made on whether to issue the authorisation and whether special conditions need to apply. The prescriber is not permitted to prescribe until they receive a signed authorisation document (usually delivered by facsimile).

The contract and the authority are for specific forms and types of medication, that is, Subutex, Suboxone and methadone all need separate contracts and authorisation; this can increase bureaucracy when making simple changes, for example, shifting from Suboxone to Subutex at onset of pregnancy. It should be possible for this to require only a notification of change to streamline clinical work

When the prescriber is no longer treating the client, they are required to notify Medicines and Poisons Control—this may be done by marking the authorisation/copy of application document as ceased, or by other written advice. The section undertakes the essential reconciliation of authorisations and prescriptions dispensed at participating community pharmacies and the OPP.

At the service level, the TADS and ADSCA services maintain an electronic record of client registration and subsequently service contact activity and all case notations in relation to the individual client. Internal audits of client records are undertaken to review content and quality and appropriateness of client management. The maintenance of client records (e.g. confidentiality, security and access) is guided by the rules associated with the use of the NT Department of Health Community Care Information System.

RESEARCH AND REPORTING

The Department also has mechanisms in place through the research and evaluation section of the AOD program for more comprehensive reporting on program activity. This is utilised for internal reporting, that required for national data collection purposes and for program data requests such as those required for this evaluation.

4.1.3 SUMMARY

It is our finding that the NT OPP functions in accordance with better practice with respect to the legislative and policy aspects of good governance. An appropriate Act is in place that provides clear guidance for the governance of the OPP supported by clinical practice guidelines. An advisory committee has been established to support the requirements of the Act and this has proved to be a beneficial mechanism for more informed decision making. A centralised system of program monitoring and reporting is in place and operational.

4.2 PROGRAM POLICIES

In the previous chapter we noted the existence of a comprehensive range of currently endorsed program policies to govern the delivery of the NT OPP. The list of current policies (appendix F) is consistent with that which was considered essential in National policy and other better practice documents.[3,4] The list was also similar to that identified in other jurisdictions, specifically Tasmania and South Australia.

The existing policies are dated between 2005 and 2007 and had not been reviewed in a number of years. In ensuring the existing policies are in line with better practice handwritten updates have been made to the existing policy, although a couple of staff noted that this has caused them confusion on occasion. The OPP staff did not identify any policy gaps that cause concern in relation to the governance, management and implementation of the program.

A process of policy review has been underway for the last 18 months and the evaluators were able to access a number of draft revisions of relevant policies (listed in Appendix F). The revised policy includes an overarching policy statement that is lacking in the existing policy.

As noted in the previous chapter, there would be value if in the process of reviewing the NT policy that other jurisdictional policy is referenced (we believe this is occurring) and the interpretation of these policies on a day to day basis are considered.

We would reinforce our recommendation from the previous chapter that completion of the policy revision should be a priority and occur as expediently as possible. Additionally, a system for more regular review (e.g. 1-2 yearly) of policy should be institutionalised and this may be aided by the planned pursuit of accreditation for the AODP clinical services.

4.2.1 SUMMARY

In summary there is a more than satisfactory range of policy to help guide daily delivery of the OPP service. The existing policies are currently under review and this offers the opportunity for discussion on interpretation of that policy in day to day practice. Completing the revision of the policies should occur as a priority.

4.3 QUALITY SYSTEMS

A range of activity is currently undertaken within the OPP that ensure the quality of the service including:

- A review of every client every second month
- Complex clients are discussed regularly at the weekly clinical management team (CMT) meeting to ensure appropriate service provision is occurring
- Internal audits of case files as a process of peer review, development and supervision
- Links with other jurisdictions and professional bodies
- Representation on National Committees
- Staff education programs
- Rotating Psychiatry registrar position

The NT OPP has also made a joint funding bid with DASSA for an addiction medicine registrar to work across South Australia and the NT which will add to the capacity and quality of the service and ideally may result in retention of such a specialist.

CLIENT PARTICIPATION IN QUALITY SYSTEM

The predominant process for client participation in the quality system has been reactive rather than a proactive approach. That is, it is based on a complaints system where clients can bring issues and concerns to management through the completion and submission of a 'pink slip'. A couple of clients noted that they had brought concerns to management and these had been responded to.

Just over twelve months ago a client satisfaction survey was introduced and this is promoted 2-3 times a year. The use of client satisfaction surveys at specific time points during the year is common place in health services particularly where formal service accreditation is being sought. We would support the ongoing systematic implementation of the surveys and subsequently review, analysis and follow up on the results.

The Rankin Court Opiate Dependence treatment program in Sydney (St Vincent's Hospital) provides an example of a client satisfaction survey that they have utilised since 2004. It is an eleven item questionnaire, covering seven domains: Overall quality of service; Access; Efficacy; Information; Professionals' skills and behaviours; Patients' input to health care; and Changes wanted by patients in clinic service delivery. Some of the key learnings from the use of the survey included:

- The results helped identify what policies/procedures need promoting;
- It was not possible to implement most suggestions and therefore it was critical that they clarified their purpose and restraints and informed clients where they could obtain the services they required;

- Educating patients and keeping them informed minimised unrealistic expectations, dissatisfaction and complaints.[18]

We would emphasise the importance of maintaining the systematic use of client satisfaction surveys in the OPP service and the ongoing analysis and follow up on the results where necessary.

In addition, better practice would propose active involvement of clients in the quality system and given the dissatisfaction expressed by some clients during the review and in other research processes, it is considered that a more proactive system for client participation should be considered. There are a number of approaches that could be considered and one or more introduced including:

ESTABLISHING A REPRESENTATIVE CLIENT REFERENCE GROUP

A significantly more proactive and challenging approach is to establish a client reference group that the service meets with on a regular (quarterly) basis to facilitate two way communication. As with the surveys, this provides an opportunity for clients to provide feedback and ask questions concerning the service and for management to provide information and the rationale for issues of client concern about the service. This is not proposed to be a forum for addressing an individual's issue, rather to address issues of common concern. This would require clear parameters and sensitive management, however would have the potential benefit of creating a high level of trust in the service.

OPEN FORUMS

In the absence of a client reference group (or in addition to), consideration might be given to facilitating open forums for clients on a regular basis. This could have two purposes: firstly to facilitate the exchange of information as discussed above; and secondly to provide education to clients on a variety of topics related to opioid dependence that are of interest to the client group. This might be challenging to establish and implement but has great potential to provide significant benefit.

4.3.1 SUMMARY

There are a range of quality activities occurring within the OPP service including the opportunity for clients to provide feedback. This could be significantly improved through strategies that actively involve clients in the quality system. This approach would provide an opportunity for the service to proactively address some of the client issues and concerns, provide rationale for decisions that are made and enable a more trusting and harmonious relationship between service and client.

4.4 PROGRAM STRUCTURE

As the OPP is currently structured, the line of accountability for the managers of both TADS and ADSCA is to the Director of AODP who in turn reports to the Executive Director of the Strategy and Reform division in the Department of Health.. There is not a reporting mechanism into the local health service (e.g. Royal Darwin Hospital or Alice Springs Hospital) and this is not uncommon for AOD programs in other jurisdictions.

In the recently announced structural reform for the Department of Health, AODP will remain accountable to the Department of Health in the 'Territory Wide Services' branch that will also include

[18] Kehoe, P & Wodak, A 2004, Patient Satisfaction In A NSW Public Opioid Pharmacotherapy Clinic: Measurement & Responses, NDARC Technical Report No.194,available at http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.194.pdf

responsibility for Environmental Health, Public Health, Disease Control and Disability Services.[19] Similar to the current situation AODP will continue to operate as a Territory-wide service. Given the relatively small size of the AODP and the OPP in particular, continuation of this arrangement would seem more appropriate and less risky than 'diluting' the service through integration with services at the local level.

In the following chapter we note the benefits of a closer working relationship with the Department of Health Mental Health services and acknowledge that work has commenced in this area particularly in the Top End. However, under the new structure Mental Health services will transition from a Departmental Territory-wide service to be embedded in the two new Hospital and Health services in the Top End and Central Australia. As part of that transition it will be important for AODP clinical services to have a clear framework for working together in practice.

4.4.1 Program structure in Alice Springs

As a result of historical relationship factors the provision of opioid pharmacotherapy in Alice Springs is divided across two services; the ADSCA service and the Alice Springs Hospital service. Whilst acknowledging there is a history to the way this structural arrangement has evolved, in a town where the recruitment and retention of experienced OPP staff is a significant challenge, and there is no compelling advantage to having two services, the structure is not a logic driven program response, but rather a result of fractured relationships and service delivery. There have been significant challenges in providing a sustainable OPP service in Alice Springs from time to time that makes this situation even more impractical.[17]

The division of the two services causes difficulties for the service and the clients in the following ways:

- There is considered to be a different ethos and service model between the two services that both the staff and clients recognise;
- There is a very poor relationship between the two services that can cause issues for the client in terms of their transition between the hospital and the community:
  - A client of ASH must dose at the community pharmacy and not the ADSCA pharmacy as they are not a client of ADSCA. Consequently, if they are banned from the only community pharmacy offering opioid pharmacotherapy, they need to be discharged from the ASH service and registered with the ADSCA service to continue dosing, breaking the continuity of care from the ASH service;
- The ASH service has a very experienced medical officer who is expected to soon be admitted as a Fellow of Addiction Medicine. ADSCA has a part-time medical officer (1 day per week) who is relatively new to AOD and OPP. This medical officer and the ADSCA team and clients are not benefitting from the expertise and additional time that would arise from greater integration between the two services.

Our consultation with staff from both services revealed that all believe the situation needs to be addressed to ensure a high quality and sustainable service for the client group. We would recommend that the relevant management for both services commence a process for achieving greater integration between the services and if feasible resulting in one service. This will be more critical with the impending structural change in NT Health.

[19] Northern Territory Government 2012, A New Service Framework for Health and Hospital Services in the Northern Territory, available at www.health.nt.gov.au/New_Service_Framework

4.5 Summary and Recommendations

The Governance arrangements for the OPP are on the whole in line with better practice. There is an appropriate Act supported by a clinical advisory committee to assist in informed decision making. There are existing program policy and guidelines that articulate the Governance and management arrangements and these are under revision. Formal authorisation mechanisms are in place and central records maintained. Program monitoring and reporting is in place. There are clear lines of accountability for management of the program.

4.5.1 Recommendations

Recommendations 1-5 included in the Philosophy and Culture domain relating to policy development and quality improvement are reinforced in the Governance section.

Recommendations specific to this section include:

6. Given the potential loss of integration between AODP and other services, (e.g. Mental Health) when these services transition to the two new Hospital and Health services, a clear framework for working together be established between AODP and relevant services.

7. The parallel OPP services operating in Alice Springs be consolidated within a single service.

5

SERVICE MODEL

The purpose of this chapter is to assess the extent to which the NT OPP service model aligns with the principles of the National Pharmacotherapy Policy and other relevant better practice. This includes the extent to which the service model contributes to access, engagement and retention of clients whilst maintaining safety and quality.

5.1 A BETTER PRACTICE SERVICE MODEL

In section 1.1 we identified the better practice principles and activities for OPP services. Those that are key to a discussion of the NT OPP Service Model specifically include:

1. Readily available and accessible for individuals who need it. Treatment is available where there are affected communities.
2. More than one single form of treatment.
3. Pharmacotherapy is part of a comprehensive treatment program, with access to adjunct services.
4. A client centred and comprehensive client assessment process and a subsequent treatment plan that is regularly reviewed.
5. Ongoing support and follow up is provided. Retention of clients in the program is a key goal.
6. Progress and continuation of drug use in treatment is monitored for the benefit of the client and not for the purpose of disciplinary action.
7. A quality program is embedded in the service.

These principles and activities will form the basis of the assessment of the NT OPP service model.

5.2 DOCUMENTED SERVICE MODEL

There is no singly specific service model description for the NT OPP available in the current policies, although a review of all policies subsequently provides a description of the service and this is in accordance with current practice within the service. Through a review of the existing OPP policies and those currently under revision, the elements can be described as listed below, however, a concise description should be documented in the revised policy.

- The specialist OPP service is integrated within a broader AOD service. In that respect, OPP staff are in fact AOD staff;
- It aims to be a specialist service supported by mainstream services. That is: providing the initial assessment and management; maintaining complex and non-compliant clients; referring on clients considered suitable for GP and community pharmacy support; providing a specialist consultation service to those community providers; taking back those clients who are non-compliant in the community based service;
- There is a multi-disciplinary team consisting of an addiction medicine specialist, experienced medical officers, nurse counsellors and other counselling professions. The Darwin service also supports a part time Psychiatry registrar on rotation;
- The treatment model includes more than one pharmacotherapy. Dosing occurs at the specialist services Monday to Saturday in prescribed hours and community pharmacy dosing is also available;
- In addition to pharmacotherapy, the specialist services include mandatory case management and counselling;
- All clients undergo a comprehensive assessment and have a treatment plan completed. Clients are stated as being central to these processes and the ongoing review of their plan. Informed consent is collected from the clients;
- In addition, there are opportunities for an authorised GP prescriber (a GP who has undertaken mandatory training requirements and been approved by CLAC) to commence clients on the OPP and for consultation support to be provided by the specialist OPP services as required and referral to those clinics should difficulties arise.

These stated characteristics of the NT OPP service model are in keeping with better practice principles and are comparable to other like jurisdictions, in particular South Australia and Tasmania.

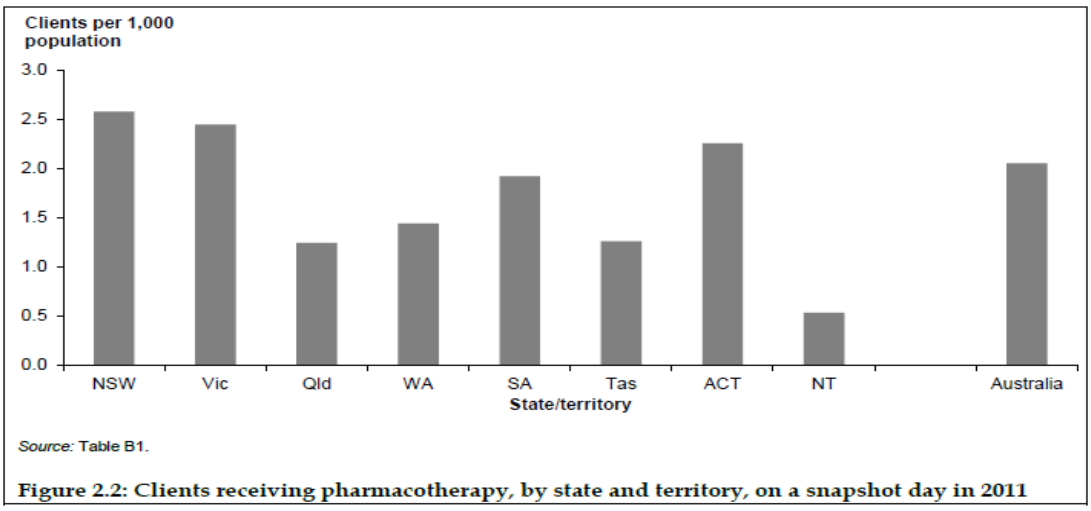
5.3 Access

A key issue for any service is to facilitate access for the relevant client group and then retain them. Access and retention is of course a product of many factors including: ethos; number and location of prescribers; number and location of dosing points, pharmacotherapies available; cost of attending and cost of the service. The following section discusses access factors, including the rate of participation and the extent to which the service is accessible for clients.

5.3.1 Level of client access

Comparative to other Australian jurisdictions, the proportion of clients receiving pharmacotherapy relative to the size of population are the lowest in Australia at 0.5 per 1,000 population. (Figure 5.1)

Figure 5.1: Clients receiving pharmacotherapy by Australian jurisdiction



(National Opioid Pharmacotherapy Statistics Annual Data 2012 collection).[6]

The reviewers gave consideration to the potential effect of the large Aboriginal and Torres Strait Islander population in the NT (comparative to the rest of Australia) and the feedback that the demand for opioid use was low amongst Indigenous people (discussed at section 2.1.5), particularly outside of Alice Springs and Darwin.

Based on an adjusted population for the NT of 140,000 people*, the 135 currently registered clients represents a ratio of 0.96 clients per 1,000 population, which is still below the next lowest jurisdictional participation rate of 1.2 per 1,000 population in Queensland. Table 5.1 below, firstly illustrates the participation ratio per 1,000 people based on the adjusted population and subsequently it illustrates the number of clients that would be registered with the OPP based on the participation ratios of other Australian jurisdictions (based on 2012 NOPSAD report).

Table 5.1: Adjusted client participation comparative to other Australian jurisdictions

Description	Population	Clients	Ratio
NT as currently reported in the 2012 NOPSAD report	230,172	123	0.53
NT with current registered clients	230,172	135	0.59
NT with adjusted population*	140,000	135	0.96
NT with adjusted population (Qld ratio applied)	140,000	168	1.2
NT with adjusted population (Tas ratio applied)	140,000	182	1.3
NT with adjusted population (WA ratio applied)	140,000	196	1.4
NT with adjusted population (SA ratio applied)	140,000	266	1.9

*The adjusted NT population is based on the ABS estimated residential population data for the NT at June 2011. The adjusted figure only includes the Darwin and Alice Springs population less all Aboriginal and Torres Strait Islander people.

This analysis of the potential effect of the Aboriginal and Torres Strait Islander population would suggest that this alone is not having a significant impact on participation rates.

Through the review processes we have not been able to definitively conclude why the NT has comparatively low rates of participation in comparison to other Australian jurisdictions. Based on the consultations with clients, potential clients and other stakeholders, we are able to conclude the following:

- The use of buprenorphine and buprenorphine/naloxone (Suboxone) as the preferred course of treatment does not appear to be a significant barrier to access;
- The location of TADS is an issue with some clients and potential clients considering that it is easier and quicker to obtain licit and illicit opioids than to spend significant time travelling to the clinic;
- Some potential clients (and clients who have previously used the program) are not using the service as they find it difficult to access and have heard (or it is their perception through experience) that the service is inflexible and punitive.

The NT addiction medicine specialist in an endeavour to further understand the participation rates in the NT has undertaken analysis of participation rates based on the number of injecting units dispensed through the NSPs. However, it was his view and agreed by the review steering committee that this was insufficiently robust to draw conclusions.

Given the significance of the low participation rate in the NT, it is recommended that a peer led multiplier study be conducted to further understand why OPP participation rates are comparatively low to other Australian jurisdictions.

5.3.2 PRESCRIBERS

As noted in Table 5.2, rates of private prescribing in the NT are comparatively low at approximately 25%. Comparative rates from other relevant Australian jurisdictions include 34.3% in Tasmania and 58.5% in the ACT. [6]

Table 5.2: Prescribers in the NT - based on 2012 NOPSAD data (snapshot day)

Prescriber	Number	%
Public	5	62.5%
Private	2	25%
Correctional Facility	1	12.5%

One of the better practice principles identified in the literature was that an OPP achieves a balance between encouraging access and maintaining safety and quality and that one of the key mechanisms for achieving this is through having a service model that includes both trained GPs and specialist services. Whilst the proportion of private prescribers can have large shifts due to the small numbers of total prescribers in the NT, it remains a fact that at the time of the review only one Darwin based GP was offering this service and none in Alice Springs or other parts of the NT. Hence, the ratio of private prescribers had in fact dropped from 25% when the NOPSAD data was collected to 14.2% at the point of the review (May 2013)

In exploring the low prescribing rates by GPs in the NT, three consistent factors were raised: a straightforward disinterest and/or not wanting to engage with the client group; a lack of confidence to manage the technical and human aspects of the program and concern about what support would be available from the specialist services; and likely as a result of the former issues not wanting to undertake the required training. These issues are discussed in more detail in section 6.2.1.

It is proposed that the following strategies might be implemented to facilitate greater involvement of GPs in prescribing.

- That broadly, there be strategies and support mechanisms implemented to encourage treatment being initiated by the GP rather than the specialist service. This would include: prescribing rights and training requirements being amended to align with a model of GP initiated treatment and that dedicated support for GPs be available through the specialist services.

- The conditions for GP prescribing could be changed (this would require changes to the Act) to allow for a GP to prescribe Suboxone for up to 5 clients without authorisation. This is the system that is being utilised in South Australia. Given this would be a significant change, this would require considered discussion within the Department.

- Rather than GP initiated treatment, a similar system that exists for Amphetamine prescribing could be implemented. The GP would become a co-prescriber for the OPP trained prescriber. The patient would be assessed under the current requirements and if deemed appropriate a co-prescriber found and the patient goes under the care and management of them. This would lessen the day to day burden but the patient would still be assessed by an appropriately trained prescriber. The GP authorisation would last one year and reassessment by the OPP prescriber undertaken once a year.

- Acknowledging that numerous attempts have been made to engage GPs in prescriber training a different approach be tried:

  – An interesting perspective was offered by a GP who previously was an authorised S8 prescriber but whose prescribing rights had lapsed. It was their view that the approach to 'selling' authorised prescriber training was errant, in that it was too focussed on opioid pharmacotherapy. The proposal was that a broader topic of training entitled 'prescribing S8 drugs' or similar should be offered that included an aspect of opioid pharmacotherapy. The view was that many GPs were concerned with prescribing S8 drugs and would attend an education session on this broader issue. This training could address some of the misunderstanding and fear, potentially stimulating consideration of the more focussed prescriber training.

Ultimately, the success of these strategies is dependent on addressing the concerns of GPs and in particular their confidence to manage opioid dependent clients and feel assured that a specialist support mechanism is available. The TADS service previously had a position allocated to GP/pharmacy liaison and the re-introduction of this position may be the first step in this process.

5.3.3 Dosing points

The availability and accessibility of dosing points is also a key factor in clients accessing and staying on the OPP. The number of dosing sites in the NT is 11. On 30 June 2011, 3 public clinics and 7 pharmacies in either Darwin or Alice Springs and 1 correctional facility were providing dosing. On that same day, approximately 17% of clients (n=21) were dosing at the public clinics. (Table 5.3)

Table 5.3: Dosing points in NT

Dosing Point	Number	%
Pharmacy	7	27.3%
Public clinic	3	63.6%
Correctional facility	1	9.1%

2011 NOPSAD report for NT

There are some similarities and some differences between the situation in Darwin and Alice Springs and hence these are discussed separately. Additionally, there is discussion regarding other locations in the NT.

DARWIN

In Darwin, dosing is only available at the OPP clinic based at the Royal Darwin Hospital (RDH) in the suburb of Tiwi and in participating community pharmacies for those clients who have met the requirements. For the latter group this is not a significant issue as the participating pharmacies are geographically dispersed.

For those clients required to dose at the RDH campus and live some distance away or are in employment, this creates a significant access problem. In particular, there are a number of clients living in the Palmerston area (estimate of approximately 25% [n=17]) who dose at the RDH and this entails a bus trip (the most common form of transport for the clients) of approximately 1 ¼ hours one-way and between 2 and 3 different buses. Accordingly, the OPP service in Darwin does not satisfactorily address the criterion of being available where affected communities are.

Both OPP staff and the clients noted that this can consequently lead to a number of clients travelling and mixing together which is a situation some clients are trying to avoid with respect to their goals. Additionally, arriving together was reported by some clients interviewed to result in greater waiting times for the last clients to arrive that can potentially lead to agitation and frustration.

For those clients who have secured employment, there is the loss of work time travelling (usually by car rather than bus) to RDH, which could be described as being isolated, potentially threatening that employment status. Additionally, it is understood through client consultation to have inhibited opportunities for employment in some cases.

There are a number of potential options to address the lack of dosing sites and difficulty in service access, some more feasible than others, but included here for consideration:

- Consideration could be given to 'relaxing' the guidelines (timeframe in particular) for clients moving to community pharmacy dosing and/or the rules regarding bringing them back to RDH for dosing for non-compliance;
- Implementing strategies that support greater GP and Pharmacy participation;
- Offering a mobile OPP dosing service at Palmerston;
- Establishing a satellite service at Palmerston through an existing facility;

- Making a capital works bid for an integrated AODP service facility in Palmerston or proposing this is incorporated in any future capital works planned for the region (e.g. new hospital or health centre).

ALICE SPRINGS

The greatest issue in Alice Springs is the significant reliance on one community pharmacist. If any client issues arise with that particular pharmacy, the likelihood is that option is removed and possibly permanently for that client. This places pressure back on the ADSCA dosing service.

We are not clear what discussion or negotiation has occurred with the other community pharmacists in Alice Springs regarding the potential for dosing. Should this not have occurred recently it is our recommendation that this be undertaken. There are significant risks having all of the community based dosing invested in one community pharmacy and alternatives should be explored. This also causes client continuity problems for ASH clients who are 'banned' from that particular pharmacy as discussed in section 4.4.1 above.

OTHER

There are currently clients in Katherine using a community pharmacy and this reportedly is working satisfactorily.

There was a potential client for opioid pharmacotherapy in Nhulunbuy and all of the arrangements were made for dosing at the community pharmacy. This ultimately was not required as the client moved back to Queensland.

Through the Nhulunbuy example illustrated above, it has been demonstrated that the specialist service model in TADS at least, can provide support to more remote areas of the NT. The sustainability of this model would be further enhanced through the implementation of strategies that encourage greater GP and community pharmacy participation.

5.3.4 OPENING DAYS/TIMES

Whilst the issue of dosing days and times were raised by both TADS and ADSCA clients, it was a particularly significant issue for those clients with the challenge of getting to the TADS clinic.

Dosing is provided at TADS and ADSCA from Monday to Saturday. On Sundays and public holidays, clients are required to attend a community pharmacy for dosing. As noted above, this did not appear to be a significant problem for clients. Community pharmacists raised concern regarding availability of OPP staff to address problems that arise on a Sunday, however, this is addressed in more detail in section 6.2.2.

The limited time available for dosing (10am – 12 noon) was raised as more of an issue and again this related more-so to the location of the Darwin clinic and the limited transport options available. To travel by bus from home to the clinic to arrive within that time frame left clients with a very limited number of departure time options. This raises issues for the clients in relation to having flexibility to attend to other critical issues. As noted above, it also results in a group of clients attending at one time that can cause challenges for both the clients and the service. Client waiting times are certainly influenced by multiple arrivals at the same time.

Whilst there are some beneficial reasons for amending the dosing times through options such as extending the time or having two sessions per day, there are resource limitations. Dosing needs to be undertaken for 2 hours on a daily basis by 2 staff (if not a pharmacist), one of whom must be a nurse.. That is all of the ADSCA OPP designated staff and approximately 20% of the TADS staff.

Increasing the hours with current staffing levels would likely unreasonably consume other critical service requirements such as assessments, reviews and routine case management. It would appear a more valuable use of time to enhance services to the Palmerston area as discussed above.

Implementation of the measures discussed above to move clients to community pharmacy earlier would partly address the limited dosing hours and in particular the extended waiting time for clients. Of course any strategies that resulted in a greater number of GP prescribers would also enhance the situation.

The Top End Mental Health service suggested that there may be opportunities for their involvement on Sundays and Public Holidays, particularly given the buildings are in very close proximity. In fact some minor structural work might facilitate access between the buildings that may assist with broader integration between the two services. This would of course require significant analysis and planning to ensure this was a feasible and cost effective mechanism.

5.3.5 COST TO CLIENTS

Under the provisions of the PBS for the Opiate Dependence Treatment Program, the drugs are provided free to dosing points. However, clients may be charged a dispensing fee when receiving medication.

In the NT, the cost to clients of the dispensing service varies depending on which service clients access; the public clinics are free whilst community pharmacy charges a fee.

The other cost that can limit people's access to opioid pharmacotherapy is the cost of travel to attend the point of dispensing. This is exacerbated when the number of dosing points are limited as they are in the NT and the population is geographically wide-spread.

Our consultation with clients did not realise significant concerns in relation to the cost at community pharmacy and/or the cost of attendance, however, it was mentioned by a couple of those clients interviewed. Similarly, our interviews with clients and potential clients did not reveal cost as an issue that affected them accessing the service.

We did note from discussion with community pharmacy and the OPP managers that client pharmacy debt can be an issue and hence the OPP has a policy (under revision) to address this specific issue. This includes, in consult with the case manager to:

- Reduce the pharmacy debt;
- Return to the public dosing service;
- If the debt is not reduced, commence on a dose reduction schedule.

As stated above, we did not encounter clients who had personally experienced payment issues and thus how this is managed particularly in relation to retention on the program.

5.4 Treatment and Adjunct Services

The service model includes both treatment and adjunct services as stipulated in the better practice principles. These are discussed below.

5.4.1 Pharmacotherapies

As is the case in other Australian jurisdictions, the pharmacotherapies currently utilised in the NT OPP include: methadone hydrochloride (methadone); buprenorphine; and buprenorphine and naloxone in combination (buprenorphine/naloxone) commonly referred to as Suboxone.[4]

Methadone is a synthetic opioid agonist that suppresses withdrawal symptoms and opioid craving for at least 24 hours. In Australia, it is currently the most common pharmacotherapy and recognised as an effective method for treating opioid dependence. The evidence from research studies and program evaluations over an extended period of time is that methadone treatment is associated with reductions in heroin use, related criminal activity, overdose and deaths, and lessens high risk behaviours associated with human immuno-deficiency virus (HIV) transmission.[20] [21]

Buprenorphine is a partial opioid agonist that has been used for pain relief in Australia since the 1980s. It was first registered as a treatment for opioid dependence in October 2000. A further preparation, containing buprenorphine and naloxone (Suboxone) was approved in 2005. Buprenorphine is considered to be an important alternative to methadone and may attract more people into treatment. Buprenorphine offers potential advantages in terms of safety, the relative ease of withdrawal, the need for less frequent administration, ease of transition into other treatments and flexibility of treatment. The effectiveness of buprenorphine is similar to that of methadone in terms of reduction of illicit opioid use and improvements in psychosocial functioning; however buprenorphine may be associated with lower rates of retention in treatment.[22] This is further illustrated in section 5.4.3.

Since the inception of the NT OPP, Buprenorphine has been the first line course of treatment (latterly Suboxone) and in fact there has been some resistance to the use of methadone, primarily because of safety concerns. This preference was based on a recommendation of the Taskforce on Illicit Drugs premised on the attributes of buprenorphine that includes; a lower overdose risk, can be dispensed on alternate days, and offers easier withdrawal for most clients.[5] Despite the higher levels of Buprenorphine usage, pharmacy and GP involvement is conversely low. The snapshot day of OPP treatment undertaken in the 2012 year shows that together Buprenorphine (11%) and Buprenorphine/naloxone (59%) represents 70% of the pharmacotherapy prescribing in the NT OPP. Methadone represents just 30% (Table 5.4).

Table 5.4: Pharmacotherapies prescribed in NT – snapshot day in 2012

Methadone	Buprenorphine/Naloxone	Buprenorphine
36	71	14
30%	59%	11%

[20] Mattick, R., Kimber, J., Breen, C., & Davoli, M. (2008). *Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence*
[21] Ritter, A., & Chalmers, J. (2009). *Polygon*. Canberra: Australian National Council on Drugs
[22] Lintzeris, N., Clark, N., Winstock, A., et al. (2006). *National Clinical Guidelines and Procedures for the use of Buprenorphine in the Treatment of Opioid Dependence*. Canberra: Commonwealth of Australia.

None of the clients or potential clients (although these were small in number) consulted considered the course of pharmacotherapy offered as being a factor negatively impacting on their choice to access or remain on the OPP.

5.4.2 Assessment and commencement

A comprehensive assessment process is undertaken prior to initial dosing including:

- Bio-psycho-social assessment
- Bloods and Urine testing
- Medical Assessment
- Induction process
- Initial dosing

This approach is considered to be better practice and ensures that both the safety of the client and the quality of the service is maintained.

There have been criticisms from clients that the time period between initial contact, assessment and then initial dose is too great. OPP management and staff acknowledge that this can be an issue that is influenced by a couple of contextual factors.

- The limited medical resource for medical assessment in both services can hold up the assessment process;
- Where methadone is to be prescribed, a minimum of 4 days of observation at the specialist service is required because of the initial risk factors. As dosing only occurs from Monday to Saturday at the specialist service, it is considered unsafe to commence methadone dosing after Wednesday at the latest. This may hold up a client's initial dosing date.

Whilst there is a need to provide a timely response to clients given the high standardised mortality ratio of untreated opioid dependence, safety for the client is paramount and thus commencement within a two week period is considered reasonable, although obviously any capacity to commence earlier is encouraged. Consultation with jurisdictional experts in both Tasmania and South Australia confer with this view.

It is also critical to point out that priority clients such as pregnant women and those with HIV are addressed in a more rapid time frame. The evaluators spoke with two pregnant clients in Darwin who confirmed this to be the case.

5.4.3 Ongoing Management

The key to enhanced outcomes for the OPP clients is retention in the program. A longitudinal and comprehensive study of opioid maintenance treatment demonstrated that outcomes significantly improve if the client remains in the program for greater than 12 months.[23]

[23] Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors, 11(4), 261-278.

Retention Rates

The CCIS data was analysed to calculate the length of stay for client episodes where the main treatment is coded as 'Pharmacotherapy'. The episodes include those with a 'Start day of Treatment' of the 1st January 2008 through to the 26th June 2012. Accordingly, it includes all of the episodes that have closed and only the current episodes (that is the episode is still open) where the period of time in treatment has been greater than 12 months.

The average, median and range of days in treatment for an episode of care are illustrated in Table 5.5 below.

Table 5.5: Days between Start day and Exit date of Treatment

Item	Days between Start day and Exit date of Treatment
Average days	124.85
Median	28
Range	0 – 1787* days (4.9 years)

* This is a current episode that commenced in August 2008 and hence the upper limit of the range will increase

Table 5.6 illustrates the number of days people stay in treatment for an episode by specific timeframes.

Table 5.6: Days between Start day and Exit date of Treatment by specific time frames

No. of Days (Band)	No of Episodes	Proportion of Episodes (%)	% Retained longer than (corresponding timeframe)
1-7 (week)	152	24.96	75.04
8-31 (1 month)	174	28.76	46.28
32-93 (up to 3 months)	108	17.85	28.43
94-186 (up to 6 months)	57	9.42	19.01
187-365 (up to 1 year)	36	5.95	13.06
366+	79	13.06	
Total	**606**	**100**	

The data illustrates:

- 46.3% are retained for longer than 3 months
- 19.0% are retained for longer than 6 months
- 13.1% are retained for longer than 12 months

Investigation was undertaken to determine whether any continuous figures on retention were kept by any jurisdiction in Australia and it is our understanding that this is not routinely undertaken.

In the National Evaluation of Pharmacotherapies for Opioid Dependence, the rates of retention for methadone, buprenorphine, and LAAM maintenance are illustrated in Figure 5.2. These rates are based on a total of 282 Heroin Users enrolled in treatment with methadone, 250 enrolled in treatment for buprenorphine and 41 enrolled in LAAM maintenance.[24]

[24] Mattick, R. et al, 2001. National Evaluation of Pharmacotherapies for Opioid Dependence: Report of Results and Recommendations. National Drug and Alcohol Research Centre, Sydney.

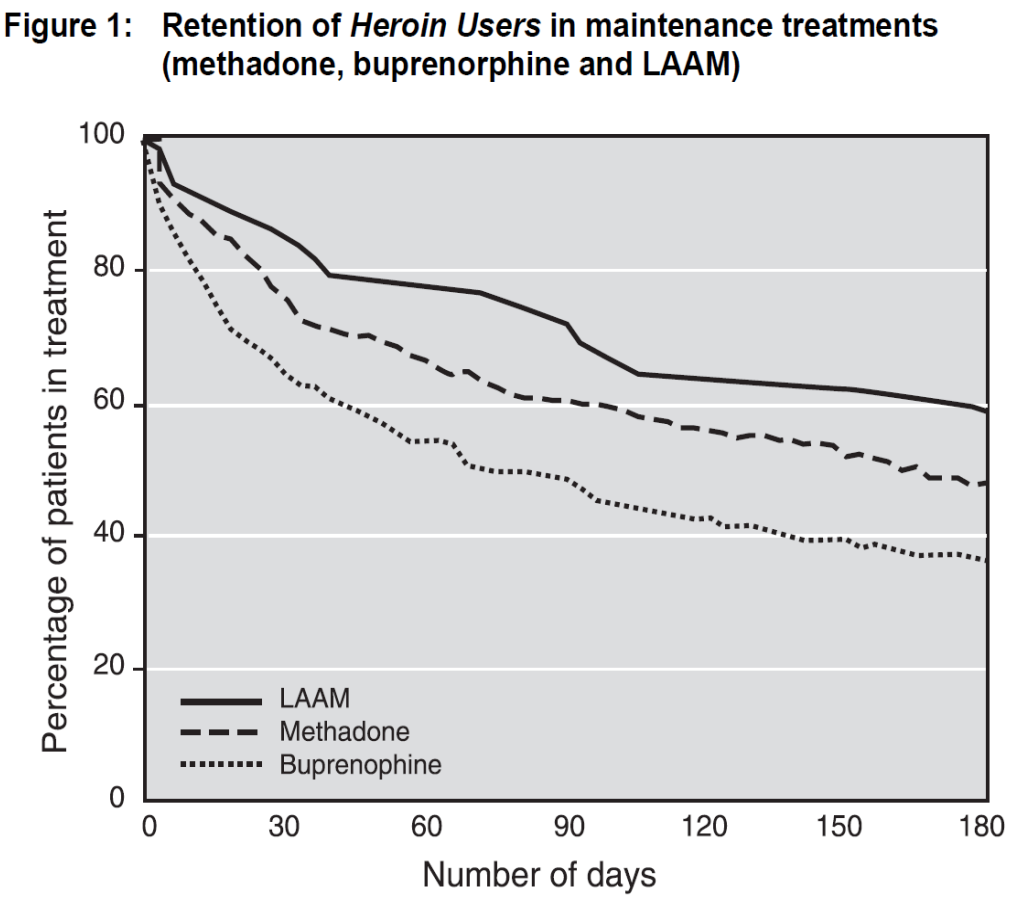
Care must be taken in making a straightforward comparison between this national data and the NT data, particularly as the NT analysis relates to episodes and not clients and very few Heroin users. In this national study:

- The retention rate for methadone treatment after 180 days was approximately 50%
- The retention rate for buprenorphine treatment after 180 days was approximately 38%
- Comparatively, retention rates beyond 6 months for all forms of pharmacotherapy in the NT is 19%

As previously noted, from our consultation with the client group and potential clients we are not able to be definitive about the reasons for comparatively low participation rates or the relatively low (in comparison to this NEPOD study) retention rates. Indicatively, the feedback in relation to the challenges of accessing the service (particularly the TADS location) and/or the perception of the service could be key indicators. Should a peer led multiplier study be undertaken this could be further explored.

Factors raised by staff in relation to the low retention rates included that the NT service was often utilised by clients who were transient and accordingly may have much shorter episodes than that seen in other jurisdictions. The data is not able to capture this, however, this could feasibly be an issue that would require exploration through alternative data analysis mechanisms.

Figure 5.2: rates of retention for Heroin users in methadone, buprenorphine, and LAAM maintenance treatments



MAINTENANCE

With respect to the maintenance phase of the OPP, two key issues were raised and it is understood that this is common across all jurisdictions.

URINE DRUG SCREENS

A number of clients and a smaller number of staff expressed concern with the process of witnessed provision of urine for urine drug screening (UDS). It is understood that at least in practice, the policy in the NT is that this is always witnessed. However, the policy under revision notes that: *'A minimum of 6 UDS per year for clients with proven stability is required with a maximum of 4 UDS per year as non-witnessed'*.[25]

Discussion with other jurisdictions suggested that a risk assessment in relation to the client determines the 'level of observation'. For example, for a client considered low risk, the staff would remain outside the door of the toilet. However, this would include observation such as the warmth of the sample and other assessment undertaken at the time as part of case management. Given the NT policies are under review and are suggesting non-witnessed UDS, there may be value in consulting with other jurisdictions as to their thresholds for witnessed and non-witnessed UDS.

As an extension of this, clients also expressed concern regarding the outcomes from the detection of other drugs in the UDS, in particular marijuana. The view was that this immediately culminated in some form of sanction such as being brought back to the clinic for dosing rather than the community pharmacy. It is appreciated that every client's situation is different and these decisions on many occasions are warranted. However, our discussion with senior clinicians in Tasmania and South Australia noted a level of 'tolerance' depending on the type, amount and the frequency of the drug and the particular client. Again the review of the policy for the NT should take account of the practices in other jurisdictions.

TAKE-AWAY DOSES

Issues relating to the opportunity to progress to take-away doses and then the number permitted are a significant challenge for the service and the clients. Following a review of other like jurisdictions policy and consultations with their senior clinicians, it is apparent that the NT is not conservative in terms of its take away policy.

CASE MANAGEMENT

Case management in the NT OPP is defined as:

A systematic approach to coordination of services to suitable clients through the efforts of assessing providers and treatments and developing treatment plans that improve quality and efficacy, while controlling costs and monitoring outcomes.

The documented case management model comprehensively discusses: clients being well informed about treatment and the service provider; co-managing their treatment; and participating in decisions about treatment, case management and all other relevant aspects of service provision.

The components of the model are documented as:

1. Developing a network – selection of services, family/friends and supporting stakeholders
2. Assessing clients – bio-psycho-social assessment

[25] NT OPP, Urine, Saliva and Blood Testing Policy currently under revision

3. Treatment planning – mutually negotiated and agreed set of goals and action plan
4. Network design – specific network for that individual
5. Monitoring and evaluation

The case management model discusses 9 domains including: Drug Use; Physical – Medications, health status etc; Psychological – current mental health status; Legal – any current or pending issues; Employment/Education or training; Family history; Social/ Housing; Risk behaviours; and Crisis management. This is a comprehensive range of bio-psycho-social domains for the case management of the client.

Given the feedback received from clients, partners and to a much lesser extent staff, it is the goal setting with clients and the networking aspects of the model that appear to be less comprehensive. The partnership aspects are discussed in more detail in the following chapter.

The relevant experience of staff is discussed in Chapter 7, however, in summary here, this is not necessarily a group of staff who would have been formally trained in case management. Given this is a fundamental aspect of the program, it is recommended that staff be formally trained in an agreed case management framework and this be a development priority.

COUNSELLING

The evidence in relation to counselling in AOD programs is that the therapeutic orientation is not as important as the therapeutic relationship and the therapeutic relationship is the most active ingredient in change. Other key characteristics of best practice counselling include:

- Supportive and empathic counselling is a sound base.
- Counselling is a joint approach between the counsellor and client with treatment plans negotiated by and agreed upon by both parties.
- Professional development is an important aspect of general counselling.
- General counselling should include the following.
  - Linking clients with appropriate services whilst client is still engaged.
  - Anticipating and developing strategies with the client to cope with difficulties before they arise.
  - Specific evidenced based interventions where appropriate (eg goal setting, motivational interviewing, problems solving etc).
  - Focus on positive internal and external resources and successes as well as problems and disabilities.
- Where appropriate, involve a key supportive other to improve the possibility of behavioural change outside the therapeutic environment
- The importance of treatment matching recognising the stage the client is at is also critical – pre-contemplation, contemplation, preparation, action, maintenance.[26]

Whilst taking into account that therapeutic orientation is not as important as the therapeutic relationship and the therapeutic relationship is the most active ingredient in change, it is considered that some form of underpinning model or theory(s) should be available to guide the 'counselling' service and the associated staff training. We note that Melbourne-based Turning Point Alcohol and Drug Centre has provided education and training in counselling for the OPP staff previously, however, it is not clear that this (or an alternative) is available to all new staff and is a sustained training activity.

[26] Ali Marsh, Ali Dale & Laura Willis, Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Literature Review 2nd edition September 2007

The service shifted to a case management and counselling focus a couple of years ago in order to integrate all aspects of treatment and adjunct therapy in a single point of contact for the individual. Whilst the existing policies document a model for case management (and included in the revised policies) this is not as clear for counselling. Additionally, we would recommend that given the primary training of most staff is 'clinically' oriented a sustainable approach to training all staff in case management and counselling is implemented.

5.5 Summary and Recommendations

The service model for the NT OPP is largely in keeping with better practice principles and is similar in approach to that found in comparable jurisdictions, in particular Tasmania and South Australia. Despite this, the participation rates for the NT are the lowest in the country. Where the challenges lie in meeting better practice, the issues are more-so contextual, and bound by resource constraints. These include: a limited number of prescribers; dosing points that are both limited and isolated from the affected community.

5.5.1 Recommendations

Recommendations 1, 2 and 5 included in the Philosophy and Culture domain are reinforced in the Service Model section. Recommendations specific to this section include:

8. A multiplier study be undertaken to further understand the comparatively low OPP participation rates in the NT.

9. Strategies be implemented to facilitate greater involvement of GPs in prescribing through:

   - strategies and support mechanisms to encourage treatment being initiated by the GP rather than the specialist service;
   - consideration of GPs prescribing Suboxone for up to 5 clients without authorisation. Given this would be a significant change, this would require considered discussion within the Department;
   - introducing the concept of the GP as a co-prescriber as is the case for Amphetamine prescribing;
   - A broader topic of training entitled 'prescribing S8 drugs' or similar be offered by an appropriate individual or agency (perhaps identified by the CLAC).

10. Enhanced access to dosing be addressed through the following mechanisms:

    - Consideration could be given to 'relaxing' the guidelines (timeframe in particular) for clients moving to community pharmacy dosing and/or the rules regarding bringing them back to the specialist service for dosing for non-compliance;
    - Support the potential for greater GP and Pharmacy participation through a dedicated liaison officer;
    - Explore the feasibility of Top End Mental Health services assisting with dosing on Sundays and public holidays in Darwin at TADS;
    - Exploring the potential for dosing at Palmerston by the specialist OPP service;

- Consulting with the community pharmacies in Alice Springs individually to further understand what the barriers are to offering the service and how this might be overcome.

11. Mechanisms be established for the ongoing analysis and monitoring of the need for OPP services outside of Alice Springs and Darwin including those that might be required to meet any future need amongst Aboriginal and Torres Strait Islander people.

6

PARTNERSHIPS

The purpose of this chapter is to discuss the extent to which partnerships have been formed with other service providers to: enhance client access to the OPP, and to enhance the range of bio-psycho-social services available to OPP clients.

6.1 DEFINITION AND IMPORTANCE OF PARTNERSHIPS

Partnerships are an important vehicle for bringing together diverse skills and resources for more effective health outcomes. They can increase the efficiency of systems that have an impact on health by making the best use of different but complementary resources. This emphasis is particularly relevant when working across multiple sectors and/or with a range of organisations. If partnerships are to be successful, however, they must have a clear purpose, add value to the work of the partners and their clients, and be carefully planned and monitored. The nature of the partnership will depend on the need, purpose and willingness of participating agencies to engage in the partnership.[27]

A distinction can be made between the purposes and nature of partnerships. Partnerships may range on a continuum from networking through to collaboration.

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners.
- **Coordinating** involves exchanging information and altering activities for a common purpose.
- **Cooperating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, a high level of trust between partners, and an ability for agencies to share turf.
- **Collaborating** in addition to the other activities described, includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system.[27]

The OPP has a diverse range of partners that can contribute to (a) facilitating greater access to the program and (b) enable the delivery of a comprehensive and holistic model of care for the client group through the case management approach. It is expected that the OPP would work across this continuum with various partners as is relevant to realise these benefits.

These partners include for example: GPs, community and hospital pharmacists, other health professionals (e.g. blood borne virus services, mental health), non-government human service organisations, and employment services. A full list of the partners interviewed as part of the review are included at Appendix C.

[27] VicHealth 2011, *The Partnership Analysis Tool.: A resource for establishing, developing and maintaining partnerships for health promotion*, Victorian Health Promotion Foundation, Melbourne

6.2 Access to and retention on the NT OPP

As has been previously stated, an evidence-based critical success factor for opioid pharmacotherapy programs is the engagement of clients that would benefit from the program, ensuring access and then retaining those clients on the program ideally for greater than 1 year. This is reliant on an effective partnership arrangement with many partners and GPs and community pharmacists in particular.

6.2.1 General Practitioners

A significant characteristic of opioid pharmacotherapy in the NT is the very low levels of community based General Practitioner prescribing in comparison with other Australian jurisdictions, including those with a similar service model (section 5.3.2). A key objective of the review was to understand the factors that were leading to this low participation through interviewing non-prescribing GPs and also to interview the prescribing GP for any lessons that might be learned.

Despite numerous attempts and different approaches (telephone, email, fax, messages) we were unable to consult with the only community based GP in the NT authorised and actively providing opioid pharmacotherapy. This has unfortunately prevented us from gaining their unique perspective on providing this service (facilitators and barriers) and the relationship with the OPP and how that service enables and supports their management of the individual on opioid pharmacotherapy, if required.

Through the review we spoke with a small number of GPs (n=4) who are not and have never been authorised to prescribe S8 drugs for the purposes of opioid withdrawal and/or maintenance. We spoke with one GP who had previously been authorised, however, due to an extended absence this authority has lapsed.

For those who have never been authorised prescribers the consistent rationale for not participating included:

- from a personal perspective they were not supportive of the concept of opioid pharmacotherapy;
- a practice-wide and/or personal decision not to provide the service out of concern that the clients might be disconcerting for other clients of the practice;
- a lack of confidence in their ability to manage the clients and a degree of fear of the clients;
- a lack of understanding of opioid maintenance and what it involves;
- concerns regarding what support if any might be provided from the specialist OPP service.

When queried as to whether some of these concerns could be addressed or allayed through prescriber training, the responses were not supportive of this being the solution. This response aligns with the Department's experience of taking numerous approaches (e.g. contracting the GP network to provide training) to encourage GPs to undertake the training as a first step, with none proving fruitful. In section 5.3.2 we proposed one potential approach that should be considered for encouraging GPs to consider the training.

The other significant issue raised by GPs was the availability of support for their practice should they decide to offer an opioid pharmacotherapy service. They were cognisant that the NT had not had an addiction medicine specialist for a considerable period of time and were reliant on support from South Australian specialists.

Some were aware of the existence of a previous OPP position based in Darwin that was focused on liaison between the specialist OPP service and community based GPs and Pharmacists. In summary, for additional GPs to participate, they would need to be assured that they would be well supported by dedicated and experienced personnel in the management of this client group. This could be enabled through re-establishing the previous TADS-based liaison position and the promotion of the telephone support service of Turning Point Alcohol and Drug Centre, the Drug and Alcohol Clinical Advisory Service (DACAS) available to NT health professionals who have concerns about the clinical management of patients and clients with alcohol and other drug problems.

This feedback emphasises the challenge of 'recruiting GPs' and offers perhaps a different approach to engagement in training and the need for a clear system of support for GPs.

6.2.2 Community Pharmacists

Similar to the situation described for GPs, the level of participation in the OPP by community pharmacists is very low in comparison to other jurisdictions. There are currently 8 pharmacies in Darwin, 1 in Katherine and only 1 in Alice Springs who are participating in the OPP. Nineteen (19) pharmacies in Alice Springs and Darwin are not participating.

As with the GPs, the review sought to understand reasons for non-participation by community pharmacies and for those offering the service any issues of concern. Accordingly we have consulted with both groups as per the list in Appendix C.

For those not participating, the reasons offered were identical to those offered by non-participating GPs: not in agreement with opioid pharmacotherapy; a practice wide decision out of concern that the clients might be disconcerting for other clients; a degree of fear of the clients; and concerns regarding what support if any might be provided from the specialist OPP service.

Participating pharmacists in Alice Springs, Darwin and Katherine provided the following feedback in relation to the day to day issues for them as a participating pharmacy.

- Pharmacists are on the whole observing positive differences and improvements in the clients over time and as a minimum, a level of stability;
- Those with a small number of clients (2-3) find that a manageable workload, however, question their capacity to manage more clients, particularly if they are challenging or not compliant;
- On the other hand a pharmacist dosing for approximately 30 clients viewed it as very time consuming but manageable. Further, they noted having developed a system for managing this number of clients including preparation on the evening before dosing;
- A number noted that dosing was not really benefiting the business commercially and hence were participating more as a community service. Further, they noted that it made dosing more accessible to clients, was more flexible than dosing at the OPP clinic and considered it to be less embarrassing and humiliating for the clients. A small number noted that it would be beneficial if there was funding to create a slightly more private area within the pharmacy for dosing;
- There were differing perspectives on 'client behaviour' with some reporting few or no issues, whilst others had been subjected to pressure, aggression and threatening behaviour. There was consistent feedback that pharmacists need to be provided training in managing aggressive OPP clients;

- Pharmacists reported an increasing mix of other drugs (some over counter / some bought on line) that have complicated management of OPP clients and others. Pharmacists consider that these issues also need to be discussed and training as required provided by OPP;

- Payment by clients is an issue for some pharmacies. One noted that it wasn't uncommon for clients to ask for their money back to buy food;

- A couple of pharmacists without prompting believed that diverting is an issue, however, also confirmed they had no proof of this. On the other hand there was a view that the use of Subutex film had reduced diversion of doses.

Our interviews with the Pharmacy Guild representatives also confirmed these as the issues they hear from their members.

Relationship with the OPP service

Through the interviews with the participating pharmacists and the Pharmacy Guild, we sought to understand the strength of the relationship with the respective NT OPP services.

In summary, it appears that communication between OPP and the participating pharmacies is minimal and difficult. Those who had experience of the situation when there was a GP/Pharmacy liaison person in particular noted the significant contrast in communication and responsiveness. Some of the key feedback included:

- Concern with the referral system between the OPP and community pharmacist;

- The service is largely faceless (not sure who to go to) and extremely difficult to contact or be responded to when required. Pharmacists feel isolated, exposed and vulnerable;

- Would like to have better communication with OPP as faxing and ringing is not always reliable;

- Would like to have more contact with the relevant case manager because it is often difficult to get in contact with the GP;

- Scripts are often not faxed through on time and then clients have to wait around before they can be dosed. "If you cannot dispense for some reason, you know that they will have to score illicitly";

- Would like some more contact and communication with the prescriber as pharmacists reported that they are often unable to get in touch with OPP particularly on the weekends;

- The public OPP service is not open on weekends so it is difficult to contact at times. Pharmacists would like to see a protocol created about how and whom to contact when they are not there as well as during the week. Pharmacists noted that this is often the time when clients will 'push boundaries' and be more difficult;

- The OPP could provide training around managing difficult behaviour and about how to manage dosing issues – even a guide book or an alternative reference for advice and direction.

These issues were supported by feedback from the Pharmacy Guild, who consider that the loss of the liaison officer in particular has affected the relationship between the OPP and the pharmacies.

If the aim of the OPP is to enhance and facilitate easier access for clients through additional dosing points, both participating pharmacies and any potential new pharmacies will need to be assured that they will be supported in the provision of this service. Consideration needs to be given to recommencing the GP/Pharmacy liaison officer position to support pharmacists, assess their support needs and provide or facilitate the appropriate responses such as provision of technical advice, training or other resources.

Both individual pharmacists and the Guild have suggested that there needs to be a working group consisting of pharmacists, GPs, OPP and other relevant parties that meets 3-4 times / year to ensure the system works properly.

6.2.3 Other referrers to the OPP

In maximising access to the OPP for clients who would benefit, other services within the NT have a role in referring or encouraging potential clients to self-refer to the OPP service. This is particularly the case for those NGOs who are often involved in providing a range of social and/or welfare support to potential clients. Similarly there are government services engaged with potential clients including Mental Health, Court Diversion, Clinic 34 (Department of Health sexual health service) that are also are potential referral points. Accordingly, they need to have an awareness of and confidence in the service.

Through the evaluation process we consulted with some of the key NGOs (see Appendix C) that would be expected to have clients who could benefit from the OPP and a range of Government services.

In summary, with the exception of the Department's Mental Health services in both Darwin and Alice Springs, the partnership arrangements between the OPP and other services, both Government and non-government, are minimal and the perceptions of the service were found to be highly critical. The specific views are discussed in the following section, however, our finding is that other services are reservedly (if at all) promoting the NT OPP to clients who would benefit from the service.

6.3 Enhancing the range of bio-psycho-social services

The second purpose for developing relationships with partners is to enable access to a range of bio-psycho-social services. As with all services, the NT OPP has limitations on the breadth of adjunct services it can provide. In the context of a case management model, it is essential that the service forms partnerships at the networking, coordinating, cooperating and collaborating levels to ensure the best possible outcomes for the clients.

To enable this, partnerships need to be developed with all of those partners discussed in the previous section: GPs, Community Pharmacists and relevant Government and NGO services. Additionally, there could be benefits from developing a relationship with education, training, job seeking/preparation and employment services.

6.3.1 Intra/Interagency Forums

It is our understanding that no form of intra or interagency forums exist involving the AODP services and relevant programs either in Alice Springs or Darwin. We are aware that specific AODP working groups are established on an as needs basis and it may well be that this is sufficient, however, our feedback suggest that this does not include any specific discussion of the OPP service.

Without any formal mechanisms for partner meetings, there is a greater requirement for the OPP services to establish more formalised partnerships with key stakeholders, ensuring of course that benefit outweighs cost. However, it is our view and is common place in the health sector that interagency meetings/forums are held for half a day on a quarterly basis largely for the purposes of information exchange.

It would be our recommendation that AODP give consideration to establishing an appropriate formal mechanism for a partners meeting with due consideration to the level that this occurs at and the programs/agencies to be involved. Once this has been determined (and perhaps a need will not be determined), the two OPP services should give consideration to the formal mechanisms that should be established with their key partners.

6.3.2 OPP PARTNERSHIPS

It is our understanding from consultation with both TADS and ADSCA, and the range of key partners, that few if any formal and informal partnerships exist between OPP and the various partners. However, we do understand that TADS personnel do visit other services and other service providers have previously engaged with clients in the period they are waiting to be dosed.

COMMUNITY PHARMACISTS

We have noted in previous discussion above that feedback from the participating pharmacies (and supported by the Pharmacy Guild) is that there are communication and referral issues with the OPP. Whilst a key partner in the program, pharmacists consider themselves to be quite isolated and would be appreciative of more contact and support from the specialist service and some discussion around responsiveness particularly out of OPP hours. This may be enabled by the AODP developing a system of support for pharmacists from the telephone support service of DACAS discussed above for health professionals.

Pharmacists are also a significant source of broader physical health information and good relationships would allow for the OPP to more readily tap into that knowledge for their clients on an as needs basis.

Pharmacists have also indicated a desire for training, particularly in relation to the management of aggressive clients. This might not be within the remit of the OPP specifically and may be a broader consideration of AODP. Additionally, this may be an issue facing other services and is an example of what could be addressed in an inter-agency forum.

Finally, it needs to be recognised that the provision of this service by community pharmacists is voluntary and of no financial benefit. This further emphasises the importance of ensuring pharmacists are encouraged to continue this role through the provision of adequate support from the OPP services.

GENERAL PRACTITIONERS

As previously mentioned, disappointingly we have not been able to consult with the one prescribing GP. Of the non-participating GPs we consulted, none advised that they had clients who were on the OPP and hence we were unable to ascertain whether there was any communication from the service to them regarding a client either in relation to the program or broader health and well-being issues.

Mental Health Services

The TADS and ADSCA services have a working relationship with Government Mental Health services around common clients. A shared care framework has been established between TADS and Top End Mental Health.

There is joint management of clients as required. This sometimes extends to joint assessment although it is understood that this is more challenging to arrange.

Both the TADS and ADSCA services have a routine of visiting the respective hospitals daily to engage with existing clients or potential clients for the OPP.

Non-Government Organisations/Other Health Programs/Other Government Agencies

Active partnerships with other relevant partners in the NT are limited. There is some interaction with other Government health programs such as the Department's sexual health clinics (Clinic 34, Centre for Disease Control (CDC)) and the sexual health and blood borne virus unit (CDC) although we understand this to be limited and could be enhanced to discuss service delivery to common clients with the aim of continual service improvement. There was similar feedback from other Government agencies such as the court diversion program.

The feedback from the NGOs consulted with is that there is no formal interaction and informal interaction is rare. We did note however, that the TADS withdrawal team undertook a liaison visit to NTAHC whilst we were in Darwin consulting, although we are unsure how regularly this occurs.

The NGOs were highly critical of the OPP service with regard to their willingness to develop relationships and partnerships for the benefit of the clients. They (as did other partners) cited difficulty obtaining responses from the service and when this did occur considered it to be largely dismissive. They are left feeling that the service is assured in its model and rules and are not open to other views.

When consulting with OPP management, there was surprise and disappointment that this view prevailed. Concern was expressed that this feedback had not been provided previously.

Other agencies

It is appreciated that the OPP service is part of a larger AOD service with staff also addressing other AOD issues. This does limit the opportunity for expanding their network beyond the partners discussed above to include other agencies such as social, welfare, education, training and employment services.

It would seem more appropriate to develop targeted, strong partnerships with the key partners discussed above, who are likely to be more oriented towards providing that type of support to OPP clients. This is premised on those relationships being repaired and/or established and maintained.

OPP Staff

During the consultations with OPP staff, we also addressed the area of partnerships with other relevant agencies. Staff noted that this was undertaken on more of an as needs basis and was an area of the service that could be improved.

None of the staff consulted offered the view that relationships with other agencies were significantly strained, however this could simply reflect the fact that there is insufficient interaction to draw that conclusion. What it would seem to support, is the notion that the OPP works in a relatively isolated way providing dosing and a limited counselling and case management role. Interaction with community pharmacy, community and inpatient mental health and the emergency department are the major areas of broader interaction.

6.4 SUMMARY

It is our conclusion that the partnerships between the NT OPP and key partners need to be improved in order to meet the dual purposes of enhancing access and enabling more comprehensive bio-psycho-social support. These partners include; GPs, community pharmacy, NGOs, and other Government partners.

To enable improved access to the service a different approach to encouraging GPs to participate in prescribing will be required. This may benefit from a broader strategy for involving GPs in prescriber training that is focussed on management of S8 drugs rather than opioid pharmacotherapy prescribing specifically.

Partnerships that will enhance the broader health and wellbeing needs of clients require significant structural and relationship attention. A number of partners have developed a poor perception of the OPP services and this likely partly relates to factors such as differing philosophies, misunderstanding about the service, and the relayed experiences of those clients they support. The lack of formal mechanisms for discussion of the program and the rationale surrounding program guidelines does not assist this situation.

Whilst there is limited use of opioids by Indigenous people particularly outside of Alice Springs and Darwin currently, it will be important to develop a partnership with the Aboriginal Medical Services Alliance of the NT (AMSANT) to remain up to date with any developments.

It is our strong recommendation that a formal mechanism be established for regular communication between the different agencies, the aim being to develop a shared understanding of the OPP, its philosophy, role and parameters and to provide a mechanism for shared problem solving and knowledge exchange.

As proposed above, consideration should be given to recommencing the previous GP/Pharmacy liaison position and expanding this to be a liaison with all key partners.

6.4.1 RECOMMENDATIONS

The recommendations in relation to the Partnership domain are:

12. A formal mechanism be established for regular communication between the different agencies/service partners related to the OPP clinical service;

13. Re-establish the previous GP/Pharmacy liaison position and expand this to include liaison with other key partners.

7

RESOURCING

The purpose of this chapter is to discuss the extent to which the service has been resourced in order to deliver the OPP. Discussion was held with the Steering Committee at the commencement of the program to consider comparative funding with other jurisdictions in Australia, however, it was concluded that this process would not be undertaken. This was premised on the difficulty in separating OPP resources from broader AODP clinical resources in the NT and this is likely to be the case in other like jurisdictions. The focus of this chapter is on human resources and physical resources and the extent to which these are a facilitator or barrier to the delivery of the OPP.

7.1 STAFF PROFILE

This section provides an overview of the staff profile currently employed in both TADS and ADSCA and overall. The information has been gathered through a survey of all TADS and ADSCA staff.

NUMBER AND TYPE OF STAFF

The following Table 7.1 illustrates the number and type of staff in both services.

Table 7.1: Number and Type of Staff – TADS and ADSCA

Staff Type	Both Sites	TADS	ADSCA
Clinical Nurse Consultant	3	2	1
Nurse Counsellor	7	6	1
Nurse	2	2	0
Nurse/Case Manager	1	0	1
Social Support Counsellor	1	1	0
Team Leader	1	1	0
Addiction Medicine Specialist (one person proportioned evenly across both services)	1	0.5	0.5
Sessional Medical Officer	1.2	1	0.2
AOD Counsellor	1	1	0
Total	18.2	14.5 (80%)	3.7 (20%)

Key points from the data include:

- ADSCA is a nurse oriented service. This likely is essential to ensure that the dosing service can be provided in keeping with the legal requirements of this being undertaken by two people with at least one being authorised to dispense (a nurse). The only alternative to this is a single dispensing pharmacist, however this is likely to be uneconomical relative to the needs of the program and more likely not to be a position that could be recruited to on an ongoing and sustainable basis.

- The ADSCA OPP service is supported by a 0.2FTE (1 day a week) sessional medical officer. The addiction medical specialist also supports the ADSCA OPP through both personal attendance and telephone consultation.

- TADS has sufficient numbers of staff to enable a multi-disciplinary service to be offered, although nursing remains the dominant profession. Not included in the data above is a Psychiatrist registrar who has a 6 month rotation through the service.

- The number of staff in each location is proportional to the client workload (based on number of clients) for each service. Whilst the number of clients in each service fluctuates, the client ratio is generally around ADSCA: 25% / TADS: 75%. From the table above we note the staffing ratio to be relative to the client workload at ADSCA: 20% / TADS: 80%.

Through our consultations we understand that:

- TADS has successfully recruited an overseas medical officer, however, this is currently held up by Australian Health Practitioner Registration Agency (AHPRA) approval processes;

- ADSCA has just recruited a social worker to cover social support counselling and is currently recruiting to the team leader position and the full time medical officer position;

- A part-time pharmacist works at TADS on Saturday mornings.

The reviewers sought to identify a benchmark for staffing levels for an OPP service. This was however complicated by broad estimates of the caseload per FTE and that OPP staff cannot very often (and certainly in the NT) be separated from their broader AOD roles. Additionally, the model of care can vary extensively from one jurisdiction to another (e.g. have limited adjunct services) thereby influencing the staff workload.

However, with respect to the number of staff to manage the NT OPP case load we noted that there was no extensive waiting list to enrol in the OPP presently although responses in the staff survey suggested that more staff are required to meet the case load. This is in contrast with the Tasmanian service for example, where it was advised that the waiting list for non-priority clients (e.g. pregnant) was in the order of months in the southern part of that State at least.

AODP could give consideration to further research on benchmark staffing levels, particularly if there is an expectation that client access may increase as a result of addressing the access issues identified in this report. This of course would need to take into consideration any shifts from the specialist service to primary care.

EXPERIENCE

The following Table 7.2 illustrates the relative experience of staff across both service and overall.

Table 7.2 Years in AOD sector

Years in AOD sector	Both Sites	TADS	ADSCA
Less than 1 year	5 (25%)	3 (17.6%)	2 (40%)
1 to 3 years	3 (15%)	2 (11.8%)	1 (20%)
3 – 6 years	5 (25%)	5 (29.4%)	1 (20%)
6 – 10 years	2 (10%)	2 (11.8%)	0 (0%)
More than 10 years	5 (25%)	5 (29.4%)	1 (20%)

Key points from the data include:

- Forty per cent of the ADSCA staff have worked in the AOD sector for less than 1 year and 60% for less than 3 years. The individual who has more than 10 years' experience is the addiction medicine specialist based in Darwin. The ADSCA sessional medical officers' experience is not included in the above data, however we understand that to be less than 3 years.
- The TADS team is much more experienced than the ADSCA team with 60% of staff having more than 3 years AOD experience. Having said that, there are still 25% of staff with less than a years' experience.

7.2 QUALIFICATIONS, TRAINING AND SUPERVISION

The following section addresses: staff qualifications, training and the process for supervision. Information has been gathered through both the staff survey and direct consultation with management and staff.

QUALIFICATIONS

The survey of staff also sought to determine the highest AOD specific qualification held by staff or that they are currently working towards. This is illustrated in Table 7.3 below.

Table 7.3 Highest AOD Qualification (or currently working towards)

Highest AOD Qualification (or working towards)	Both Sites	TADS	ADSCA
Advanced Diploma Community Services (AOD Work)	1	1	0
Diploma	2	2	0
Certificate IV in AOD Studies	7	5	3
Graduate Diploma in Addiction and Mental Health	1	1	0
Post Graduate Certificate	1	1	1
Master Social Work	1	1	0
Bachelor of Psychology (Hons)	1	1	0

Key points from the data include:

- Two of the three ADSCA staff have completed or are working towards completing the Certificate IV in AOD studies. This is considered to be a good achievement given 2 staff has been in the sector for less than a year and the third less than 3 years.
- Twelve of the fifteen Darwin based staff (this includes the addiction medicine specialist) have undertaken or are working towards an AOD qualification. The qualifications range from advanced diploma to medical speciality.
- Comparatively, the ADSCA service staff are relatively new to working in the AOD sector and accordingly don't have the range and extent of qualifications as the TADS team.

TRAINING

Further to the formal qualifications discussed above, other points raised through the staff survey in relation to training include:

- The majority of staff commented that there were no gaps in training, although a number did express concern around the limited number of staff provided with the opportunity to attend interstate training and conferences. It was the opinion of some staff that this opportunity is only being provided to medical officers and that this is a relatively new occurrence (meaning it was previously not the practice of the OPP). It is our understanding that this reflects a change in policy instituted by the new Government in August 2012 whereby interstate travel has been significantly limited for DoH staff. It is now considered on a case by case basis and staff may need to contribute to the costs depending on the expense involved.
- This issue of restricting training according to position type was cited as the most significant barrier, along with the fact that not all staff can attend training given staff must actually be present on the premises to deliver the actual service. The distance of training (given most are run interstate) is also not as accessible for some staff. In-house training was suggested frequently to address this issue. Overall, the majority of staff did not believe there were any further barriers to receiving training.

- The main form of regular internal training is the weekly in-service program. This is provided following the weekly clinical management team (CMT) meeting, which is often a source for identifying in-service topics.

- The majority of staff agreed that skills and knowledge around communication, counselling, assessment, service coordination, cultural awareness, pharmacotherapy specific information, community development, health promotion and project management were essential in undertaking their role. An understanding of mental health and comorbidity, as well as an ability to establish rapport with clients and communicate in a transparent and client centred manner was also a common response.

On this latter point, the survey did not ask a specific question related to the number of people who had been trained in Case Management and Counselling. It is noted however, that some staff members have been trained or are completing training as Mental Health Nurses, Social Workers, Psychologists and Psychiatrists.

Given that case management and counselling are central to the OPP service model, it is considered essential that all staff are trained in these areas, relevant to the counselling and case management models determined for the NT OPP. Through our consultation with management, we understand that whilst some staff have had formal training ('Turning Point' has provided counselling education and training), it generally occurs as more of a mentoring and on-the-job training process with support from those who are highly experienced.

It is recommended that a relevant and appropriate training course for case management and counselling be identified for the OPP staff and that this is a priority development activity for those staff with limited knowledge and experience in this area. This case management and counselling training strategy could be offered more broadly or facilitated in partnership with other members of the AOD sector in the NT including NGO partners.

Supervision

There is a comprehensive system of staff supervision in place that includes both internal supervision and external supervision. The weekly clinical management team meeting, where staff present complex client cases for discussion in relation to their management, offers another opportunity for supervision.

7.3 Service Management

As noted in the sections on AOD experience and qualifications above, the personnel with management responsibilities across the service are those with more than 10 years of experience and post graduate qualifications in AOD.

Our consultation with staff noted a high degree of satisfaction with OPP managers. There was consensus that the managers had an 'open door policy' for discussion of concerns at any time. Whilst staff noted the above concerns with accessing training, there was consistent feedback that the management supported staff wherever it was possible within the resource restraints, for example with time off to attend training.

The vast majority of staff commented that they considered the OPP service to be the best workplace they had experienced and felt highly supported.

Attraction/Recruitment

Through the staff survey, staff reported that in order to attract new staff or enhance the recruitment of qualified staff to the sector generally, the OPP could consider providing permanent positions as opposed to temporary contracts. This would provide staff increased security, rotation through different roles to maximise experience, assist with relocation costs and ensure career progression and acquisition of AOD qualifications.

Retention

The staff survey identified that the following changes would make a marked difference in their role and on their willingness to remain in their position:

- Continued training and professional development (funded by AODP)
- Greater flexibility in working arrangements
- Improved physical environment
- Increased staff numbers so that client load is more manageable
- Improved remuneration, to reflect the complexity of the clients managed
- Less bureaucracy and more stability in management
- Electronic system for prescribing
- More doctors.

In terms of staff achieving their career aspirations, the most common response was that there are some barriers to these attempts, particularly the cost of obtaining a specific AOD qualification and the provision of temporary contracts over permanent positions.

Staff also reported on a number of factors that were most likely to influence staying in their current role. These include the business hours which the OPP keeps which ensure flexibility and work/life balance, a supportive team and manager and the belief that they are contributing to the OPP and its clients in a meaningful way.

In comparison, the factors which were most likely to influence staff in leaving their role include the salary, stress levels relating to managing complex clients and if there was a negative change in manager or team.

In order to enhance retention of staff, respondents suggested an increase in professional development, job security through the provision of permanent contracts, an increase in staff to manage case load and stress and a focus on self-care.

7.4 Physical Resources

Two key issues were raised by staff and management in relation to the provision of the OPP service.

- The case management and counselling activity is not enabled by the layout of the physical facilities, particularly in Darwin. There are multiple large rooms where staff are sharing space, but limited smaller private counselling rooms. The rooms that are available for counselling are said not to be particularly soundproof.

- An electronic system for prescribing was considered important in relation to enhancing productivity (reduced paperwork) and improved accuracy.

It is our understanding from consulting with the DASSA who provide clinical services (e.g. addiction medicine specialist) to the NT that the technological support for the provision of services by the NT OPP is comparatively advanced, for example, the saliva drug testing capacity.

7.5 SUMMARY

Our consultation with OPP staff noted a high degree of satisfaction with OPP managers. There was consensus that the managers had an 'open door policy' for discussion of concerns at any time. There was consistent feedback that management supported staff wherever it was possible within the resource restraints. The vast majority of staff commented that they considered the OPP service to be the best workplace they had experienced and felt highly supported.

The lack of experienced AOD staff within the ADSCA service, exacerbated by the small number of staff is of concern. The capacity to recruit experienced staff is shown to be limited.

Given case management and counselling are fundamental activities of the NT OPP this should be a priority development activity for those staff with limited knowledge and experience in this area. Additionally it could be offered more broadly to the AOD sector in the NT including NGO partners.

The key issues with respect to physical facilities are the TADS service not being ideal for the purposes of providing case management and counselling and the need for an electronic system for prescribing by Medical Officers.

7.5.1 RECOMMENDATIONS

The previous recommendation in the Governance section concerning the consolidation of the parallel OPP services in Alice Springs is reinforced in this Resourcing section. Recommendations specific to this section include:

14. Investment in the training of inexperienced staff in ADSCA is critical given the small team. The Department should make the training of this staff a priority based on an assessment of identified need.

15. The continued and regular involvement of the NT's current addiction medicine specialist in the ADSCA service is considered essential.

16. A relevant and appropriate training course for case management and counselling be identified for the OPP staff and if appropriate offered to the broader AOD sector including NGOs.

17. Opportunities to undertake minor works that would support improvement to the facilities at TADS should be pursued.

18. An electronic system for prescribing should be investigated and assessed for its cost benefit.

19. AODP could give consideration to undertaking research on benchmark staffing levels for an OPP service.

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APPENDIX A – KEY EXPERTS

The following people are the key experts consulted in the design stage of the project who were utilised to provide input into the better practice principle of an OPP.

- Dr Adrian Reynolds - Clinical Director, Alcohol and Drug Services, Department of Health and Human Services, Tasmania. Dr Reynolds is also a steering committee member for the review.
- Dr Paul Williamson - Manager, Pharmacotherapies Research Unit, Drug and Alcohol Services South Australia (DASSA), SA Health
- Dr Anna Woods, Senior Consultant, Eastern DASSA, SA Health
- Professor Louisa Degenhardt – Senior Research Fellow, National Drug and Alcohol Research Centre (NDARC), The University of New South Wales
- Professor Steven Allsop – Director, National Drug Research Institute (NDRI), Curtin University

We were unsuccessful in our attempts to make time with Associate Professor Nick Lintzeris, Director, Drug and Alcohol Services, Langdon Centre, South East Sydney and Illawarra Area Health.

Professor Margaret Hamilton was approached, however due to existing commitments she was unable to assist at the time. Professor Hamilton holds the current positions: Professor, Melbourne School of Population Health, University of Melbourne; Chair, Drug Policy Modelling Program (DPMP) Advisory Group, The University of NSW; Executive member, Australian National Council on Drugs (ANCD); Chair, National Illicit Drug Campaign Reference Group; Chair, Cancer Council Victoria Board.

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APPENDIX B – REVIEW STEERING COMMITTEE

Name	Position	Organisation
Mr Craig Cooper	Executive Director (Chair)	NTAHC
Dr Steven Skov	Community Physician	NT DOH - CDC
Dr Leon Nixon	NT Addiction Med Specialist	NT DOH – AODP (Member - CLAC)
Dr Adrian Reynolds	Clinical Director	DHHS - Alcohol and Drug Services, Tasmania
Ms Judith Oliver	Director	NT Branch Pharmacy Guild
Ms Helgi Stone	Manager	NT DOH – Medicines and Poisons Control (Chair - CLAC)
Ms Sarah Gobbert	Manager	NT DOH - TADS (Member - CLAC)
Mr John Gaynor	Manager	NT AODP - ADSCA
Ms Sandra Schmidt	Manager	NT AODP - ADSCA
Ms Fiona Clarke	Community Representative	NTAHC
Mr Kelvin Dargan	NGO AOD Representative	Director - Banyan House
Mr Samuel Ireland	Aboriginal Health representative	Danila Dilba
Ms Lesley Woolf	Aboriginal Health representative	Danila Dilba
Ms Jo Murray	Senior Adviser (Secretariat)	NT DOH - AODP

NB: Mr John Gaynor and Mr Samuel Ireland left their positions during the course of the review and were replaced by Ms Sandra Schmidt and Ms Lesley Woolf respectively.

Key

ADSCA Alcohol and Other Drug Service Central Australia

AODP Alcohol and Other Drugs Program

CDC Centre for Disease Control

CLAC S8 and Restricted S4 Clinical Advisory Committee

DHHS Department of Health and Human Services

NTAHC Northern Territory Aids and Hepatitis Council

TADS Tobacco Alcohol and Other Drugs Service

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APPENDIX C – STAKEHOLDERS CONSULTED

Steering Committee	
Name	**Position and Organisation**
Mr Craig Cooper (Chair)	Executive Director, Northern Territory Aids and Hepatitis Council (NTAHC)
Dr Leon Nixon	Addiction Medicine Specialist, Alcohol and Other Drugs Program (AODP), Member – S8 and Restricted S4 Clinical Advisory Committee (CLAC), NT Department of Health,
Ms Judith Oliver	Director, Pharmacy Guild, NT Branch
Ms Helgi Stone	Manager, Medicines and Poisons Control / Chair - CLAC, NT Department of Health
Ms Sarah Gobbert	Manager, Tobacco Alcohol and Other Drugs Services (TADS), Member – CLAC, NT Department of Health
Mr John Gaynor	(former) Manager, Alcohol and Other Drug Services Central Australia (ADSCA), NT Department of Health
Ms Sandra Schmidt	Manager, Alcohol and Other Drug Services Central Australia (ADSCA), NT Department of Health
Ms Fiona Clarke	Community Representative, NTAHC
Mr Kelvin Dargan	NGO AOD Representative, Banyan House
Jurisdictional Experts	
Dr Paul Williamson	Drug and Alcohol Services South Australia (DASSA), SA Department of Health
Dr Anna Woods	DASSA, SA Department of Health
Professor Louisa Degenhardt	National Drug and Alcohol Research Centre (NDARC), University of NSW
Dr Adrian Reynolds	Clinical Director, Alcohol and Drug Services, Department of Health and Human Services, Tasmania
Professor Steve Allsop	Director, National Drug Research Institute (NDRI)
Key Stakeholders	

Dr Katrien Depraetere	Medical Officer, ADSCA, NT Department of Health
Dr Jennifer Delima	Medical Officer (Addiction Medicine), Alice Springs Hospital (ASH), NT Department of Health
Mr Justin Heath	(former) Acting Manager, Nhulunbuy Residential Rehabilitation Centre, AODP, NT Department of Health
Dr Shirley Hendy	Medical Officer, TADS, NT Department of Health / Member - CLAC
Ms Sophie Higgins	A/Director & Pharmacist, Central Australia Hospital Network, ASH, NT Department of Health
Mr Brad Carter	Community Pharmacist, Priceline Pharmacy, Alice Springs
Mr Adrian Marshall	Community Pharmacist, Amcal Max, Casuarina, Darwin
Dr Natasha Pavlin	Public Health Medical Officer (Top End) - AMSANT
Other Stakeholders	
Non-Prescribing GPs	
Dr Sarah Giles	CDU Medical Centre (FCD Health)
Dr Jeanine Richardson	Cavenagh Medical Centre
Dr Sherly Silva	Palmerston Medical Clinic
Dr Satbir Aulakh	Top End Medical Clinic
Non-Participating Pharmacists	
Steve Large	Humpty Doo Amcal Pharmacy
How Wan Ooi	United Discount Chemist, Darwin
Linda Leong	Barden's Amcal, Parap, Darwin
Louise	Amcal Max Pharmacy, Nightcliff, Darwin
Shammy	United Discount Chemist Northside, Darwin
Gavin	Chemist Warehouse, Casuarina, Darwin
Participating Pharmacists	
Jaimee Anderson	Katherine Value Plus Discounted Pharmacy, Katherine
Sarah	Palmerston Value Plus Pharmacy, Palmerston
Tee	Save Mart Pharmacy, Winnellie, Darwin
Maryum Abas	Harrison's Shop 201 Pharmacy, Casuarina, Darwin

Marcus Leong	Stuart Park Pharmacy, Stuart Park, Darwin
Others	
Maria Giacon	Pharmacy Representative, NT Department of Health – Alice Springs Pharmacy
Angela Young	Director of Pharmacy, NT Department of Health, Central Australian Hospital Network
Dr Colin Marchant	Medical Officer, Central Australian Aboriginal Congress (CAAC)
Frances Padgin	General Manager, Top End Mental Health Department of Health,
Lisa Coffey and Judy Clisby	Commissioner and Deputy Commissioner, Health and Community Services Complaints Commission
Kim Meighan	Clinical Nurse Consultant, Nhulunbuy Residential Rehabilitation Centre, NT Department of Health
Rebecca Katiforis	Clinical Nurse Consultant, Centre for Disease Control (CDC), Clinic 34 Darwin, NT Department of Health
Professor Bob Batey	Visiting specialist, CDC, Clinic 34 Alice Springs, NT Department of Health
Leigh Moore	NT Representative, Pharmaceutical Society of Australia Ltd
Dr Howard Flavel	Rehabilitation Specialist, Top End Hospital Network, Territory Integrated Pain Service (TIPS), NT Department of Health
Clients recruited and interviewed	
A total of 56 clients and 3 non-clients were consulted with during the review. For privacy and confidentiality reasons their names are not recorded here. Recruited through: Community Pharmacy -7 NTAHC -32 (11 in Alice Springs, 9 in Darwin, 12 in Palmerston) TADS -13 ADSCA -7	

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APPENDIX C – FUNCTIONS AND POWERS OF CLAC

NT *Poisons and Dangerous Drugs Act,* Part VAA, Section 31R

Functions and powers of Committee

(1) The Committee has the following functions:

(a) to advise the Chief Health Officer about the competency required by medical practitioners to supply Schedule 8 substances or restricted Schedule 4 substances;

(b) to recommend to the Chief Health Officer appropriate accredited training programs for medical practitioners who are to supply Schedule 8 substances or restricted Schedule 4 substances;

(c) to provide expert advice to the Chief Health Officer about the treatment of persons (whether generally or in relation to a particular person) with Schedule 8 substances or restricted Schedule 4 substances;

(d) to advise the Chief Health Officer in relation to the granting, variation, suspension or revocation of authorisations under Part VA, Division 3; (d) to advise the Chief Health Officer in relation to the granting, variation, suspension or revocation of authorisations under Part VA, Division 3;

(e) to make recommendations to the Minister about matters to be included in the Guidelines;

(f) to provide advice to the Chief Health Officer about whether matters relating to the supply of a Schedule 8 substance should be referred to the Medical Board of the Northern Territory;

(g) to advise the Chief Health Officer about policy issues in relation to the supply and use of Schedule 8 substances and restricted Schedule 4 substances;

(h) any other advisory functions in relation to Schedule 8 substances or restricted Schedule 4 substances conferred on the Committee by or under this or any other Act;

(i) any other advisory functions in relation to Schedule 8 substances or restricted Schedule 4 substances conferred on the Committee in writing by the Chief Health Officer.

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APPENDIX D – PRINCIPLES OF HARM REDUCTION

The principles of harm reduction as outlined in the Harm Reduction: British Columbia Community Guide (2005) (Appendix 1B) are summarized below.

PRAGMATISM

Harm reduction recognizes that drug use is a complex and multi-faceted phenomenon that encompasses a continuum of behaviours from abstinence to chronic dependence and produces varying degrees of social harm. Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a universal phenomenon. It acknowledges that, while carrying risks, drug use also provides the user and society with benefits that must be taken into account.

HUMAN RIGHTS

Harm reduction respects the basic human dignity and rights of people who use drugs. It accepts the drug user's decision to use drug and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges an individual drug user's right to self-determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and management.

FOCUS ON HARMS

The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it recognizes the need for strategies at all stages along the continuum of drug use.

MAXIMIZE INTERVENTION OPTIONS

Harm reduction recognizes that people who use drugs benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is providing options and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the creation of effective harm reduction strategies.

PRIORITY OF IMMEDIATE GOALS

Harm reduction starts with "where the person is" in their drug use, with the immediate focus on the most pressing needs. It establishes a hierarchy of achievable interventions that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. Harm reduction is based on the importance of incremental gains that can be built on over time.

DRUG USER INVOLVEMENT

Harm reduction acknowledges that people who use drugs are the best source for information about their own drug use, and need to be empowered to join the service providers to determine the best interventions to reduce harms from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives. The active participation of drug users is at the heart of harm reduction.

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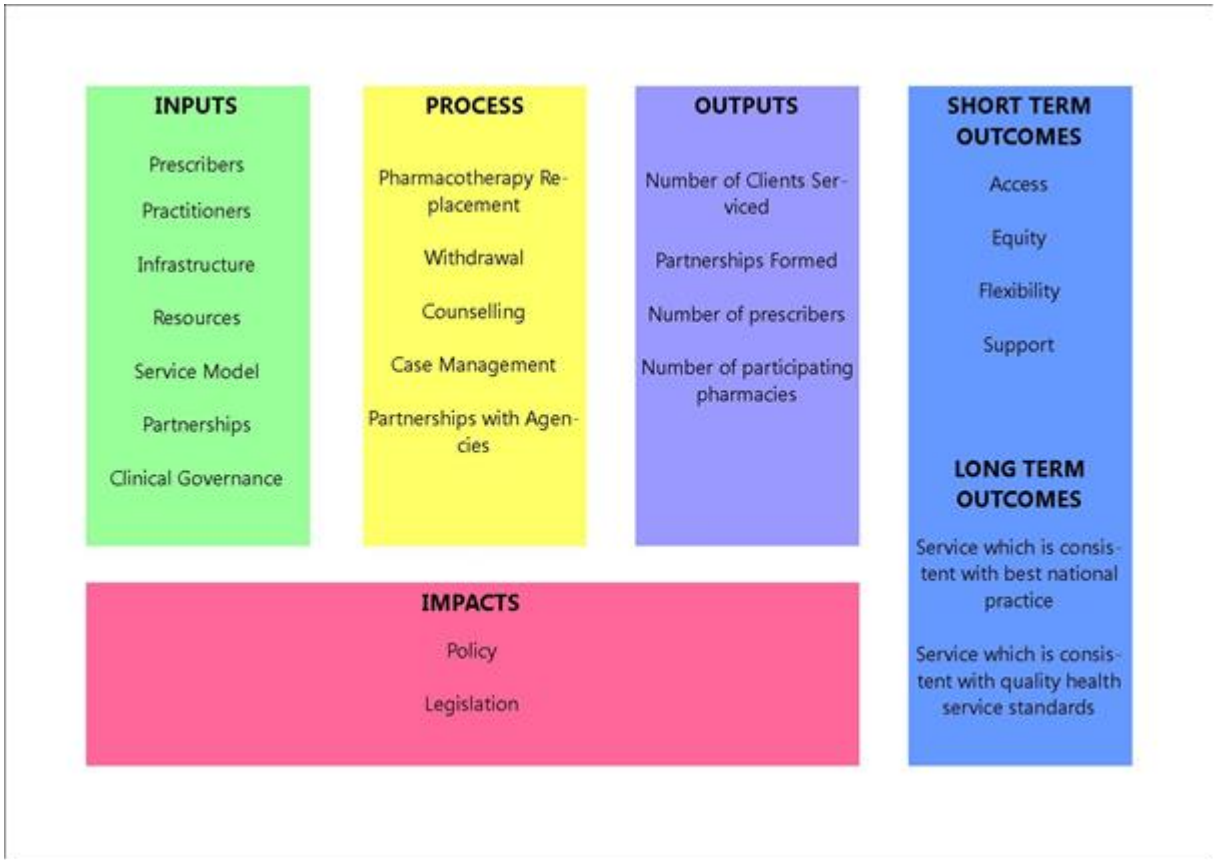
APPENDIX E – PROGRAM LOGIC FOR NT OPP



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APPENDIX F – NT OPP POLICY

Currently endorsed policies (dated 2005 -2007)

The OPP policies form part of a larger policy manual for AODP clinical services. Policies specific to the OPP include:

1.1 Priority Entry

1.2 Induction of Clients

1.2.14 Pregnant Client on Buprenorphine and Methadone

1.3 Referral to Withdrawal Services

1.4 Regular Assessment of Client Progress

1.5 Dose at commencement of Program

1.6 Urine and Blood Testing

1.7 Stabilisation of Pharmacotherapy

1.8 Prolonged Dispensing at ADS Dispensary

1.9 Medical Review

2.1 Take away methadone, Buprenorphine and Suboxone

2.3 Provision of Test Results

2.4 Couples on the Program

2.5 Missed Doses for Clients

2.6 Restoring Dose levels after missed doses

2.7 Response to vomited doses

2.8 Restabilisation of Buprenorphine/Methadone- Upward Dose Adjustment

2.9 Assessment for Methadone Dose Splitting/Increase above 150mg

2.10 Methadone Intolerance, Use of Methadone Tablets (Physeptone) and Undiluted Takeaways

2.11 Acute Pain and Rescue Doses

2.12 Involuntary Reduction and Ceasing of Buprenorphine or Methadone

2.13.1 Prevention and Management of Overdose and Intoxication

Policies currently in draft form include:

- Pregnant Women

- Priority Entry
- Induction
- Medical Review
- Dose at Commencement
- Stabilisation
- Urine, Saliva and Blood Testing
- Missed Doses and Restoring Doses
- Vomited Doses
- Cyclone Dosing
- Prolonged Dispensing at Specialist Clinic Pharmacy
- Interstate Referrals, Transfers and Holidays
- Pharmacy Debts
- Sickness Certificates.

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APPENDIX G – REVIEW MATRIX

Domain	Key Research Question	KPIs	Data Analysis	Data Sources
Philosophy and Culture	To what extent does the philosophy and culture of the NT OPP align with the principles of the National Pharmacotherapy Policy and other relevant better practice? How does it act as a facilitator and a barrier?	• Overarching policy statement exists • Harm reduction oriented • Service model is client centred • Proportion of people accessing the service • Proportion of clients retained in OPP > 6 months and > 12 months • Reported facilitators and barriers • Evidence of appropriate response to barriers to service delivery	• Review of policy and program data and documentation • Qualitative analysis of consultations	Policy/Procedure Program Data OPP Staff AODP staff Partners Clients/Non clients
Partnerships	To what extent have partnerships been formed with other service providers to enhance access to the OPP for clients? What are the facilitators and barriers to these partnerships?	• Source of referrals • Proportion of GPs prescribing • Proportion of pharmacies dispensing • Reported facilitators and barriers	• Review of program data and documentation • Qualitative analysis of consultations	Program Data OPP Staff AODP staff Partners GPs/Pharmacists

Domain	Key Research Question	KPIs	Data Analysis	Data Sources
	To what extent have partnerships been formed with other service providers to enhance the range of bio-psycho-social services of OPP clients? What are the facilitators and barriers to these partnerships?	• Integration with other AOD programs • Evidence of partnerships with and referrals to other relevant services • Reported facilitators and barriers	• Review of program data and documentation • Qualitative analysis of consultations	Program Data OPP Staff AODP staff Partners GPs/Pharmacists Clients/Non client
Governance	Do the Governance arrangements for the OPP ensure compliance with legislation, national policy, accountability, safety and quality, program monitoring and reporting?	• Appropriate legislation exists • Overarching policy statement exists • Procedural arrangements for authorisation are in accordance with the legislation • Accountability arrangements are clearly documented • Relevant operational policy and procedure is documented • Quality systems are in place and operational • Client participation in quality system • A system of program monitoring and reporting is in place and operational • Evidence of appropriate response to barriers to service delivery	• Review of legislation, policy and program documentation • Qualitative analysis of consultations	Policy/Procedure OPP Staff AODP staff Partners

Domain	Key Research Question	KPIs	Data Analysis	Data Sources
Service Model	To what extent does the service model align with the principles of the National Pharmacotherapy Policy and other relevant better practice? To what extent does the service model contribute to the engagement and retention of clients whilst maintaining safety and quality? How does it act as a facilitator and a barrier? Are there particular sub-groups within the target group that the model does not accommodate or satisfy?	• There is a clearly defined service model • The service model is client centred • Goal setting with clients • The service model includes treatment and adjunct services • Services are available where affected communities are • A range of relevant operational policy exists to guide service delivery • Multiple treatment forms are available • There is a consistent and comprehensive assessment process and treatment planning • Clients report continuity of services between case managers • Profile of clients accessing the service • Client engagement (relevant to population) and retention rates • % of clients involuntarily terminated • Re-engagement of clients involuntarily terminated • Opening days/times • Reported facilitators and barriers • Evidence of appropriate response to barriers to service delivery	• Review of policy and program data and documentation • Qualitative analysis of consultations	Policy/Procedure Program Data OPP Staff AODP staff Partners Clients/Non clients

Domain	Key Research Question	KPIs	Data Analysis	Data Sources
Resourcing	Is the service staffed by an appropriately experienced and skilled workforce? Are the physical resources appropriate to safe and quality service provision? Is the allocated funding sufficient to meet demand and safe, quality services? What are the key barriers to service provision (if any) arising from the available resources?	• Leadership and management of the service is provided by appropriately qualified and highly experienced personnel • Service delivery staff are appropriately skilled and experienced and/or systems are in place to provide relevant training and development • Staff turnover rates • Systems are in place and operationalised to provide training for prescribers • Physical resources meet the requirements for safe and quality service provision • Availability of service (times/locations) • Waiting time to access the service • Reported funding barriers • Evidence of appropriate response to barriers to service delivery	• Review of policy and program data and documentation • Qualitative analysis of consultations • Staff survey • Staff turnover rates	Policy/Procedure Program Data OPP Staff AODP staff Partners Clients/Non clients

TACKLING ICE IN THE NORTHERN TERRITORY

breaktheice.nt.gov.au

NORTHERN TERRITORY GOVERNMENT

MESSAGE FROM THE CHIEF MINISTER

There is genuine concern across the Northern Territory and throughout Australia about the impact that ice is having on individuals, families and the community.

In smaller communities, the impact of ice and other forms of methamphetamine can be devastating.

The Northern Territory has historically high rates of overall illicit drug use among its youth and adult population. In addition to this complex social issue, we are also facing an alarming increase in ice use, drug-related offending and resultant harm across the community that needs immediate and decisive action.

Ice use does not discriminate, and it is not confined to particular groups. That is why any actions need to be informed by evidence, and effectively coordinated across government agencies, the non- government sector and communities.

Regular use increases dependence, with friends and families often bearing the brunt of the physical, mental, financial and legal consequences. The earlier a person starts using drugs, the greater their risk of harm, including mental and physical health problems, and the greater their risk of continued drug use. This is where supportive friends, family and schools play an important part.

Effective policing and a robust criminal justice system are critical to reducing the supply and availability of ice - however, it is acknowledged illicit drugs will never disappear completely. Effective drug management involves law enforcement activities working hand in hand with evidence-based education, prevention and treatment responses.

We need to make sure we are educating and ultimately stopping Territorians from using ice or other drugs. Parents and schools must work together so our children can learn to make the right decisions about personal health and safety and to positively influence their decisions around drug use.

For whatever reason, there will be always be people in society who use drugs, including ice.

Many of those will never seek treatment. They feel that their drug taking is 'under control' and will continue to use. We need to support these people to manage or stop their drug use if and when they ask for help.

Recognising that it is a very complex problem, *Tackling Ice in the Northern Territory* sets out what we're already doing and what we will do to address the health, social and legal problems that ice use is causing to individuals, families and the community.

The Hon Adam Giles

BACKGROUND

In developing *Tackling Ice in the Northern Territory*, the Northern Territory Government recognises the importance of a coordinated and balanced approach to addressing drug problems.

All government agencies, non-government services and the community have a part to play in reducing the harms associated with ice, but some agencies take a lead role.

The departments of Education, Health, Children and Families and the Northern Territory Police Force all have a critical role to play. Other agencies also contribute to developing effective responses.

These agencies must share information and work together to develop, implement and evaluate strategies to address ice use and supply across the Northern Territory. Reporting against achievements will show where progress has been made and also identify where more attention is needed.

The immediate priorities are developing and overseeing implementation of the Ice Action Plan and responding to the recommendations of the NT Committee Inquiry on Ice and the National Ice Taskforce Final Report.

Government alone cannot solve drug problems. We need effective partnerships with non-government organisations and Aboriginal Medical Services that provide education, treatment and aftercare services, particularly in remote and regional areas. These services are supported by both Northern Territory Government and Commonwealth Government funding.

It will be updated in early 2016 to respond to any additional recommendations from the NT Committee Inquiry on Ice and the National Ice Taskforce Final Report.

Tackling Ice in the Northern Territory sets out what the Northern Territory Government will do now as a priority to tackle ice and what it plans to do.

WHAT IS ICE AND HOW IS IT AFFECTING TERRITORIANS?

Methamphetamine is a stimulant that comes in a range of forms, including powder (speed), paste, liquid, tablets and crystalline (ice). Ice is the purest and most potent form.

Ice is not a new drug issue but all available evidence shows a rise in the number of Australians using ice and a significant increase in the severity of harm caused by taking ice.

Not only are there more people using methamphetamine, more people have changed from using powder (speed) to ice. There are also more injecting drug users who now use ice.

More people are seeking treatment, more people are self-reporting ice use through surveys and research and there has been a steady upward trend of amphetamine type substances (ATS) seizures in the Northern Territory for the past four years.

The purity of ice is increasing, but can fluctuate significantly from purchase to purchase. A person using ice will not know how strong it is until they use it -the effect, and their reaction, can vary significantly.

Families often bear the brunt of an individual's ice use through increased aggression and violence, relationship breakdown or through financial problems. Families are also likely to be the main support network and play a vital part for people wanting to cease or manage their ice use. Ensuring families and community groups have access to credible information, effective treatment services and supportive networks is a priority.

As well as having negative health and social impacts, the use of ice is illegal. People who use ice are more likely to come into contact with the criminal justice system whether from purchasing the drug, supplying it to others or engaging in criminal behaviour, such as property crime, to maintain their drug use.

Northern Territory Police have reported an increase in seizures and weights over the past financial year. The profit margins for ice are significant in the Northern Territory, making it an attractive drug market to organised crime groups. Members of the community can assist by providing police with information about drug activity – especially where it is believed it is being supplied or produced.

Research shows that drug related crime has changed and there is increased prevalence of firearms, weapons and violence associated with drug trafficking. This impacts significantly on community safety and requires considerable policing resources.

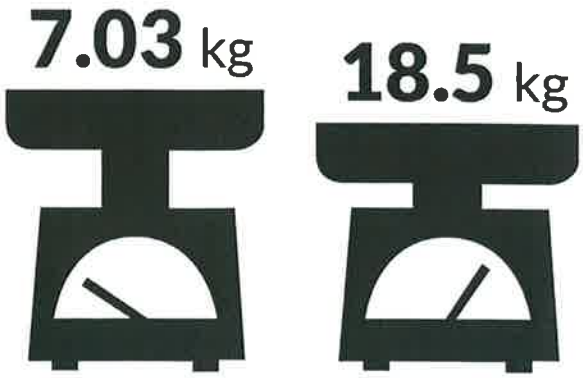
Direct drug defined offences, such as the possession, manufacture or distribution, of illicit drugs is increasing, with dependent users being repeat offenders. Dependent users often supply other users to help support their own habit; which can lead to them owing drug debts.

Repaying these debts often involves other drug related offending, including property crime, acts of violence (such as reinforcing other debts or reinforcing 'turf'). Other issues include the increasing feelings of vulnerability, psychosis and paranoia. Dependent users of the drug are often involved in weapon and firearm incidents - with theft of drugs and firearms a source of financing future drug deals and owning certain areas for drug distribution.

NT Police undertake considerable work to disrupt drug trafficking. As methamphetamine is a synthetic substance, targeting the sale and supply of precursors, other 'ingredients' and equipment is a key priority in reducing the local manufacture of ice. Intercepting drug traffickers and mules who are regularly used to transport the drug between jurisdictions (often as a result of their own drug debts) also helps to reduce supply.

Ice is not a common substance seized on its way to Indigenous communities, but there is concern that increased awareness about the drug may lead to more people wanting to try it.

This reinforces the need for a combined approach of law enforcement activities to reduce supply, effective and credible messages around prevention and education, including recognising signs of use, and appropriate training for health centre and frontline staff.



The total weight of amphetamine type substances (ATS) seized in the NT rose from 7.03kg in 2012-13 to 18.5kg in 2013-14

The number of amphetamine type substances (ATS) seizures in the NT increased from 350 in 2012-13 to 447 in 2013-14

WHAT ARE THE EFFECTS ON SOMEONE WHO USES ICE?

The effects of using ice vary depending on how much is used, how it is used, purity of the drug, frequency of use and the situation it is used in. It can be swallowed, smoked, snorted or injected – however, smoking is the main method of using ice.

When someone uses ice, they may experience:

- Feelings of pleasure and confidence
- Increased alertness and energy, talkative
- Repeating simple actions like itching and scratching
- Dilated and enlarged pupils and dry mouth
- Teeth grinding, jaw clenching and excessive sweating
- Fast heart rate and breathing
- Reduced appetite
- Increased sex drive, reduced inhibitions and unsafe sexual behaviour
- Restlessness and agitation
- Aggressiveness, paranoia and psychosis.

Long term, heavy or dependent users may experience psychosis, paranoia, hallucinations and mood swings. Problems may be compounded by existing mental health, physical, psychological and social issues.

People who inject methamphetamine may experience problems related to injection such as collapsed veins, abscesses and the spread of blood-borne viruses like Hepatitis B and C or HIV.

Taking ice with other drugs can be unpredictable and even more dangerous. Combining ice with other stimulants such as ecstasy can place enormous strain on the heart and other organs, leading to a stroke. Using ice with depressants such as alcohol, cannabis or benzodiazepines can mask their effects and in the case of benzodiazepines, increase risk of overdose.

A criminal conviction arising from drug use, supply or trafficking has major long term consequences on family relationships, employment opportunities and will also mean the person cannot travel to some overseas countries.

Using ice can lead to serious health, legal, social and financial consequences.

No matter which way you look at it, using ice is just not worth the risk.

WHAT HELP IS AVAILABLE FOR PEOPLE WHO USE ICE?

People using ice, or their family members, can get support from a range of Government and non-Government services across Darwin, Alice Springs, Tennant Creek, Nhulunbuy and Katherine.

Alcohol and other drug workers in remote communities can also help.

General practitioners can help users and their families by providing referrals to a treatment service.

Services operate through a combination of Northern Territory Government and Commonwealth Government funding.

Treatment includes assessment, information, counselling, withdrawal, residential rehabilitation, outreach and telephone support services.

The Alcohol and Drug Information Service is a good starting point for users or their family members. It is a confidential hotline and trained counsellors can offer advice, information and referrals to local treatment services. It is accessible 24 hours a day, seven days a week on 1800 131 350.

Anyone experiencing a mental health crisis or concerned about someone's wellbeing can call 1800 682 288 (for a free and confidential 24 hours a day service).

Where possible, treatment involves family members. This provides a supportive environment and helps everyone involved understand the problem, accept it and work together to make changes.

Harm from ice use is increasing and this is reflected in data collected from government and non-government treatment services, hospitals and health centres.

In 2013/14 there were 90 treatment episodes, climbing sharply to 245 in 2014/15.

Treatment episodes include those who attend a service for an assessment and discussion of their drug use but choose not to proceed with any follow up treatment. This accounted for 56% of all treatment provided in 2013/14 and 38% in 2014/15.

Counselling remains the most commonly accessed treatment type, accounting for 15% of all visits in 2013/14 and 33% in 2014/15.

Residential rehabilitation accounted for 17% of treatment provided in 2013/14, dropping slightly to 15% in 2014/15.

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OUR APPROACH

Harm minimisation

Reduce the demand for ice through education and prevention

Reduce the availability of ice through effective policing

Reduce harms caused to individuals, families and communities by providing counselling, treatment and support services.

This will be supported by:

Ensuring actions across government, non-government services and the community are coordinated, informed by evidence and reflect the diverse needs of different population groups

Developing a local workforce with the skills, knowledge and experience to provide appropriate support and advice for people wanting to stop using ice or to use it in ways that reduces potential for harm

Commitment to collecting, analysing and sharing research and data to improve policy, practice and treatment approaches.

Focus on education and prevention

What we're doing now

- Finalising locally produced evidence-based resources to support teachers and parents to better educate young people about ice. These will be completed by April 2016
- Funding grants to communities and organisations to promote local drug awareness, education and prevention programs
- Providing counselling services to Northern Territory Government school students, including responding to critical incidents which may relate to the abuse of ice by a student or parent
- Facilitating access to school-based drug education programs run by external providers
- Referral of youth offenders to drug education programs.

ACTION PLAN

1. Schools and parents help build resilience in young people by talking openly about the harms of drug use and making informed choices
2. Provide accessible and evidence-based information to increase community understanding about the effects of drugs use
3. Educate people by delivering peer to peer support and community-based programs designed to help people talk honestly about their drug use and how it affects them.

What we will be doing in the future

- Implementation of the positive behaviour and wellbeing program in NT government schools
- By April 2016, produce resources for young people, including posters in local Indigenous languages that are evidence based and target those areas most at risk.
- Produce communication strategies that are evidence based and target those most at risk
- Improve access to telephone information, counselling and follow-up services, and ensure hotlines incorporate methamphetamine expertise
- Review youth diversionary programs to identify how they can be more effective.

Reduce the supply, manufacture and distribution of ice

What we're doing now

- Taskforce NEMESIS – screening of major passenger flights and all drug routes into the NT – targeting of known drug suppliers/ importers into the NT
- Strengthening the *Misuse of Drugs Act* to enhance search and seizure powers on drug trafficking routes
- Participation and engagement at the state and national level to improve regulation and controls on precursor chemicals and equipment used to manufacture ice.

ACTION PLAN

1. Strengthen legislation where possible to make it easier to identify and prosecute suppliers
2. Share intelligence with interstate and overseas to learn what policing methods work best
3. Improve identification of drug dealers and clandestine laboratories through strong community partnerships to reduce the amount of ice on the streets
4. Monitor sales of chemicals and equipment to make it harder for people to manufacture ice.

What we will be doing in the future

- Amendments to the *Misuse of Drugs Act* and *Sentencing Act* to create new offences, increase police powers and create higher maximum penalties for serious drug offences
- Identify further legislative measures relating to criminal property forfeiture
- Work closely with local councils to develop specific supply reduction initiatives.

Reduce harms caused to individuals, families and communities

What we're doing now

- Providing alcohol and other drug treatment resources and services to the areas of highest need
- Reviewing grant management practices to ensure that services are cost effective and meet the needs of local communities
- Funding needle and syringe programs to minimise the spread of blood-borne viruses such as human immunodeficiency virus (HIV) and hepatitis B and C
- Programs for youth and adult detainees to address drug use and post-release support.

ACTION PLAN

1. Encourage safer practices for people who use drugs
2. Provide easily accessible information on websites and through telephone hotlines so individuals and families can seek confidential advice, support and treatment
3. Reduce the stigma and marginalisation associated with ice use so individuals and their families don't feel ashamed to ask for help
4. Fund and support community-led approaches to identify and help solve local issues.

What we will be doing in the future

- Trial the HOPE (Hawaii's Opportunity Probation with Enforcement) strategy, which applies swift sanctions for unlawful drug use, to increase offenders' ability and motivation to participate in behavioural change processes
- Investigate a trial of needle and syringe vending machines
- Work with high-risk industries where current use is understood to be relatively high to improve workplace responses to ice use
- By February 2016, distribute resources to assist individuals, families, carers and communities to identify the signs of ice use and how to seek help from local support services
- Develop an online toolkit to support families and communities to better understand and address the problems caused by ice
- Reduce road trauma harms by amendments to the Traffic Act to enable drug driver testing in more circumstances.

Encourage people to work together and share ideas

What we're doing now

- Attendance at local, and national forums and conferences to exchange information
- Participation in national committees to develop drugs policy, treatment approaches and law enforcement responses
- Regular meetings with community groups to identify local issues and help them to put solutions in place.

ACTION PLAN

1. Respect all services, support groups, agencies and clients to reduce the stigma of drug use
2. Hold community forums to share and exchange information and ideas on what can be done
3. Encourage new ideas to reduce demand, supply and harm.

What we will be doing in the future

- Hold community forums in Darwin and Alice Springs in early 2016 to share information and exchange ideas
- Fund community level activities to address risk factors that lead to drug use
- Strengthen collaboration between the mental health and alcohol and other drug sectors.

Build a responsive workforce

What we're doing now

- Increasing local Indigenous employment in the Alcohol and Other Drugs sector
- 'Yarning about Ice' tool and presentation for government and non-government Primary Health Care Centres
- Providing National Accredited Training to staff in non-government and government services
- Improving training and protective equipment for frontline police respondents engaging with persons affected by illicit drugs.

ACTION PLAN

1. Attract and retain suitably qualified people so that people seeking help get the best advice
2. Enhance career opportunities for remote and regional Indigenous people to ensure culturally appropriate support
3. Develop workplace policies, procedures and training for those who come into contact with ice users and/or their families to enable them to help them and stay safe
4. Encourage professional development to ensure counselling and clinical skills are up to date.

What we will be doing in the future

- Implement evidence-based national treatment guidelines
- Increase opportunities for regional and remote people to gain Certificate IV level qualifications in Alcohol and Other Drugs
- Placement of after-hours Alcohol and Other Drugs liaison worker in Emergency Departments to assist with prompt specialist management and the commencement of withdrawal.

Improve the evidence base

What we're doing now

- Conducting local and national research to determine the use and impact of drug use
- Analysing treatment data to determine trends and areas of high demand
- Reviewing data collections to ensure they are as informative as possible
- Collecting data on critical incidents, suspensions and counselling in schools.

ACTION PLAN

1. Increase investment in local research projects to identify what is happening
2. Collect, analyse and share data to better understand the problem
3. Use evidence to develop better policy, strategy and treatment services
4. Work with other states and territories to learn from each other about what is working.

What we will be doing in the future

- Review local and National surveys to enhance data collection, analysis and reporting
- By June 2016, implement an NT Alcohol and Other Drug research and evaluation strategy
- Invest in local research and evaluation projects to inform policy and practice.

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NORTHERN TERRITORY GOVERNMENT

Review of the Needle and Syringe Program in the Northern Territory

Report for the Northern Territory Department of Health

November 2011

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Contents

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Executive summary

The Northern Territory Department of Health commissioned Anex to undertake a review of the Northern Territory Needle and Syringe Program (hereafter the NT NSP). The review assessed the effectiveness and efficiency of the NT NSP in meeting its objectives. Specifically, the review identified (i) the extent to which the objectives of the NT NSP have been achieved, and (ii) whether current NSP services represent the most appropriate, effective, and efficient means for achieving these objectives. A mixed methods approached was employed including consultations with a range of stakeholders including NSP service providers and clients. Quantitative NSP data from the Department of Health was also analysed.

Table 1: Summary of findings

SERVICE DELIVERY MODEL	
Strengths	**Areas for Improvement**
• Majority of secondary NSP outlets are located at the CDC/Clinic34s and provide a comparable range of services as the primary NSP outlets. • Situating NSP in organisations such as NTAHC and the CDC/Clinic34s enables clients to access a range of complementary programs and services offered by these organisations, thereby adding value to the NSP.	• The Program is reliant on relatively small and narrow categories of organisations providing NSP services. The implications are that issues of access for priority population groups, and accessibility of services, are not able to be addressed adequately. Expanding the number of secondary NSP outlets into other relevant organisations would be appropriate. • Additionally, to address issues of access and accessibility, consideration should be given to other service modalities (e.g. mobile/outreach and/or syringe vending machines).
PROGRAM OUTPUTS	

Strengths

- Injecting equipment available at NSP outlets are appropriate to the types of drugs that are injected and appropriate to addressing the potential injection-related harms associated with them. As there are no limits placed on numbers of sterile injecting equipment distributed, the Program is sensitive to the geographic issues present in the Territory.
- A range of strategies are employed to provide clients with health information and education, which are relevant to the issues identified as pertinent for clients.
- Clients are referred to a range of health and social services.
- Inappropriately discarded used injecting equipment in public places is not a significant issue in the Northern Territory – clear evidence that the efforts of services to educate clients about appropriate disposal have been effective.
- Incidence of HIV and HCV infections are below the national average, and rates of sharing of used injecting equipment is lower than the national average.

Areas for Improvement

- Limited uptake of wheel filters by clients was expressed as a concern. More proactive approaches to promote awareness of the benefits of using wheel filters and to address attitudes and perceptions of clients regarding their use should be considered.
- An awareness of blood borne virus transmission and prevention remains an important issue for the Program and should be maintained.
- A reliance on passive awareness raising campaigns, one-on-one and opportunistic education may impact efficiency of providing health information and education. Group approaches should be considered.
- More proactive approaches to initiate discussion with clients rather than to rely on clients to raise problems may convey a more positive and inviting environment and influence clients' willingness to raise potentially sensitive issues with staff.
- Physical layout of services is an important factor that influences clients' willingness to raise problems for discussion with staff. Services should be mindful of the impact of their physical layout.

CLIENT PROFILE

Strengths

- Numbers of visits by clients of Aboriginal/Torres Strait Islander background accessing the Program (while small compared to total number of clients) increased between 2007 and 2009.

Areas for Improvement

- Improving access to NSP to people living in the Long Grass, as well as injectors living within or near the suburb of Nightcliff.
- To extend the penetration of information into the injecting drug use population, consider ways to tap into current information networks.

PROGRAM COVERAGE

Strengths

- NSP outlets are located at each major population centre across the Territory.
- Program coverage across a 24-hour period and throughout the year appeared to be adequate in most population centres.

Areas for Improvement

- Geographic and temporal coverage in Darwin is limited as the main services are located within the CBD. Improving geographic and temporal coverage is required.
- Reliance on hospital emergency departments as the only source of after-hours and weekend access to sterile injecting equipment is vulnerable to a range of factors which may lead to restricted or no access. Alternative modalities to achieve after-hours and weekend access such as syringe vending machines should be considered.

LINKAGES AND PARTNERSHIPS

Strengths

- Strong intrasectoral linkages among NSP outlets.
- Primary NSP outlets are well-linked with a range of other agencies and organisations. Given the strong intrasectoral links, secondary outlets are able to refer clients to the primary outlets for further assistance, and clients are able to benefit from the linkages formed by the primary sites.

Areas for Improvement

- Establish formal links with the Northern Territory Police, and develop appropriate protocols aimed at facilitating access to NSP services by injecting drug users who may not be accessing services due to fear of police harassment.

WORKFORCE AND DEVELOPMENT

Strengths

- Stable workforce comprising of staff who have many years of experience and who are committed to providing NSP services. On-the-job training provided by these staff members appear to be adequate in transmitting these attitudes to new staff members.
- Staff at primary NSP sites possess and/or are required and supported to obtain appropriate formal qualifications which provide competencies in working in community services and/or with alcohol and drug related issues.
- Primary outlets provide opportunities for new secondary NSP staff members to visit and learn about how the Program is delivered which is considered useful.

Areas for Improvement

- The last formalised workforce training occurred six years ago. Increasing the frequency of formalised training for the workforce is warranted. This would include understanding rationale for NSP services, knowledge of types of drugs that are commonly used and the implications for service delivery, and importantly, potential issues faced by clients and ways to address client needs.
- The primary NSP sites set the benchmark for NSP service provision. To ensure consistent baseline knowledge and understanding across the NSP workforce, a formalised method for site visits should be considered.
- Access to site visits by secondary NSP staff may be limited due to distance for some outlets. Supporting staff from distant regional centres to visit primary NSP site as part of their induction to providing NSP services should be considered.

PROGRAM COSTS

Strengths

- Per unit cost for consumables appeared to be comparable to most other Australian jurisdictions.
- Reliance on secondary NSP outlets to supplement the primary outlets means that Program coverage is increased at minimal cost.

DATA COLLECTION AND ANALYSIS

Strengths

- Data is collected on volume of equipment distributed which allows for ongoing monitoring of trends.
- Data is collected by NSP outlets on client demographics.

Areas for Improvement

- Client demographic data from all outlets is not collated and reported to services. The main drawback is that the capacity to monitor Program reach and penetration is limited. Standardised data collection forms and reporting mechanisms are in place, however improvements in data collection and reporting from secondary NSP outlets is warranted.

The review found that the outputs of the NT NSP are consistent with its objectives. Specifically, the NT NSP continues to supply equipment that are suitable to the types of drugs that are injected, and have the potential to prevent injecting-related harm associated with these drugs. The policies surrounding the supply of sterile injecting equipment are also sensitive to the geographic issues that are evident within the Northern Territory thereby minimising the potential negative impact from large geographical distances. There was a decline in volume of equipment distributed in 2010 compared with previous years. Whether this represents an anomaly or is indicative of a downward trend should be closely monitored.

The NT NSP continues to provide clients with access to health information and education through a range of strategies including accessible written material in the form of pamphlets and brochures, coordinated education and awareness raising campaigns, and one-on-one opportunistic education episodes. These strategies target a number of pertinent drug-related issues that are experienced by clients such as pill filtering and safe disposal of used injecting equipment. Uptake of wheel filters, which would be a more effective means of filtering a pill-based drug mix and thereby prevent injection-related injuries, is low. More proactive approaches to promote awareness of the benefits of using wheel filters and to address attitudes and perceptions of clients regarding their use should be considered.

While it is important to address emerging issues, care needs to be taken that persistent ongoing issues such as blood borne virus transmission and prevention are not neglected. There is no evidence to suggest that this is the case, but services should be mindful that prevention of blood borne virus transmission remains important.

The NT NSP continues to provide information and referrals to a range of health and social services to clients including mental health services, general practitioners, and other alcohol and drug services such as detoxification and pharmacotherapy services. Compared with reported episodes of information and education provision, the number of referral episodes reported is low. However, referral episodes are vulnerable to the types of agencies available to which clients could be referred, and to clients' willingness to raise potentially sensitive issues with staff. The range of referrals provided to clients indicated that the NT NSP is fulfilling its role as a first point of contact between clients and the health

and social service system. More proactive approaches to initiate discussion with clients rather than to rely on clients to raise problems would convey a more positive and inviting environment and influence clients' willingness to raise potentially sensitive issues with staff. A review of the physical layout of services to address any perceived barriers that this may impose should also be considered.

Inappropriately discarded used injecting equipment is not a significant issue in the Northern Territory. Efforts of services to educate clients about appropriate disposal of used injecting equipment therefore appear to be effective.

Finally, based on the data collected through the primary NSP outlets, there is a general trend for an increase in numbers of client visits by people of Aboriginal/Torres Strait Islander backgrounds, although they constituted a small proportion of total client visits. Number of visits by clients of Aboriginal/Torres Strait Islander backgrounds during 2010 was an exception to this general trend and should be monitored to determine if it is indicative of an ongoing downward trend. Similarly, access by injectors from rural and other locations to NSPs in Darwin and Palmerston should be investigated

A number of strengths characterise the NT NSP. These include cohesive and supportive services that are well linked with each other, and an experienced workforce that is committed to its objectives. The primary NSP outlets play a key role in providing a critical link between the NSP sector with a range of other agencies and organisations. The strong relationships between the secondary outlets and the primary outlets suggest that secondary outlets which may have limited capacity to refer clients onto other health and social services, may potentially and reportedly do refer their clients on to the primary sites for further assistance.

While the current service delivery model of the NT NSP appears to be appropriate and effective in delivering its objectives, further improvements are required to respond to persistent and emerging issues and challenges. Specifically, while coverage is adequate in most population centres in the Northern Territory, there is a need to improve access to services across geographic locations, and across a 24-hour period throughout the year. This issue is particularly significant for Darwin where arguably the majority of injecting drug users are located. There is also a need to improve access to services for injecting drug users generally as well as for specific sub-groups such as people who are

homeless and living in the "Long Grass". To respond to these issues, increasing the number of NSP outlets is warranted. This could be achieved in a number of ways including establishment of outlets within relevant organisations that are providing services to these populations, introducing mobile/outreach services, and introducing syringe vending machines which have been successfully introduced in other Australian jurisdictions. Assessing the prevalence of injecting drug use in rural and remote communities may be warranted in the future to the extent that it may assist in determining the need for NSPs to be established in these areas.

Additionally, while a formalised and standardised training package is available via the Alcohol and Other Drugs Program of the Department of Health, it is not provided with sufficient frequency or regularity. The lack of availability of regular and timely formal training programs for staff should therefore be addressed. The development of appropriate monitoring processes such as improved reporting mechanisms would be helpful to enable continued planning and improvement of the NT NSP. Given that fear of police harassment is an impediment to accessing services for injecting drug users, it is critical for the Northern Territory Police and NSP to work collaboratively to develop protocols aimed at facilitating access to NSP services by injecting drug users.

The review identified a number of issues which require further investigation. Understanding the prevalence of steroid injecting, and the knowledge and practices of steroid injectors in regard to preventing associated harms (such as blood borne viruses) would be useful to determine the extent to which it is a potential problem in the Northern Territory. Given that pharmaceutical opiates are the main drugs injected and that uptake of wheel filters is low, injecting drug users in the Northern Territory are potentially at risk of a range of injection-related injuries such as abscesses and skin ulcers which if untreated may lead to further infections and possible amputation. An assessment of the prevalence of injection-related injuries and harms may be warranted. Finally, a number of issues were raised in relation to the opiate pharmacotherapy program including its accessibility and the potential negative impact of the policies surrounding its operation on patients. A review of the operation of the opiate pharmacotherapy program and patient outcomes should be considered.

Based on an analysis of the findings from the review a number of recommendations were identified. These recommendations are reproduced below – beginning with recommendations for the Department of Health, followed by recommendations pertaining to NSP services. It is recommended that:

1. The **Department of Health** maintain the current level of funding for NSP, and undertake regular reviews on the need for increased funding to address emerging issues and challenges.

2. The **Department of Health** improve the reach and penetration of the NT NSP (particularly in Darwin) through expanding the number of outlets including the establishment of additional secondary outlets situated in relevant agencies that provide services to priority groups (including the Long Grass People, and injectors living within or around Nightcliff).

3. The **Department of Health** improve coverage of the NT NSP through the expansion of service delivery modalities including the introduction of syringe vending machines to improve after-hours access to sterile injecting equipment.

4. The **Department of Health** continue to monitor the trends in NT NSP outputs and client visits.

5. The **Department of Health** provide financial assistance to secondary NSP outlets in distant regional centres to enable induction of new staff through visits to primary NSP sites.

6. The **Department of Health** review current arrangements in relation to workforce development and training to ensure that formalised training is provided to all staff on a regular basis with appropriate frequency.

7. The **Department of Health** liaise with NSP services to ensure that quality of data collected and reported on client visits is of a standard that would enable the reach and penetration of the NT NSP to be assessed over time.

8. The **Department of Health** facilitate the establishment of formal linkages between the NSP sector and Northern Territory Police with the aim of improving access to NSP services by injecting drug users.

9. The **Department of Health** provide funding to enable an investigation into the prevalence of steroid injecting within the Northern Territory, and its associated harms.

10. The **Department of Health** provide funding for an assessment of the prevalence of injection-related injuries and harms associated with pharmaceutical opiates.

11. The **Department of Health** undertake a review of the operation of the opiate pharmacotherapy program and patient outcomes.

12. **Primary NSP services** review and formalise the program for site visits by new NSP staff across the Territory so as to contribute to consistent knowledge and understanding of NSP-related matters across the NSP workforce.

13. **NSP services** continue to maintain and promote awareness among clients of safe storage and disposal of injecting equipment; safer injecting practices (including the use of wheel filters); and blood borne virus transmission and prevention.

14. **NSP services** be more proactive in promoting client awareness of the benefits of using wheel filters and address attitudes and perceptions of clients regarding their use.

15. **NSP services** investigate the use of group approaches to complement existing strategies for information provision and education for clients, and consider ways to utilise peer information networks to improve the reach and penetration of health promotion messages to injecting drug users.

16. **NSP services** be mindful of the impact of physical layout on clients' ability and willingness to approach staff to discuss problems, and where possible to minimise the negative impact.

17. **NSP services** take a proactive approach in providing information, education and referrals to clients.

1. Introduction

1.1. Needle and syringe programs in Australia

First introduced in Australia in 1987, Needle and Syringe Programs (NSPs) are a public health measure and are a key component of Australia's *National Drug Strategy 2010 – 2015* (Commonwealth of Australia, 2011). They have also been identified in the *Sixth National HIV Strategy 2010 - 2013* and the *Third National Hepatitis C Strategy 2010 – 2013* as an important feature in Australia's approach to preventing blood borne virus transmission.

The value of NSPs in preventing blood borne virus infections is substantial. An estimated 32,050 HIV and 96,667 hepatitis C (HCV) infections in Australia have been averted between 2000 and 2009 by making sterile injecting equipment available through NSPs (National Centre in HIV Epidemiology and Clinical Research (NCHECR), 2010a). Savings from treatment costs avoided for HIV and HCV are estimated to be up to $1.28 billion.

NSP services are provided in all Australian states and territories in metropolitan, regional, rural and remote settings. They are the most common source of needles and syringes for injecting drug users in Australia, followed by pharmacies (Iversen, Topp, & Maher, 2011). Nationally, more than 32 million needles and syringes are estimated to have been distributed each year (NCHECR, 2010a).

Aside from enabling access to sterile injecting equipment for the prevention of blood borne viruses, information and education on issues relating to injecting drug use and health, referrals to other health and social services, as well as support may be available from NSP services. These services also contribute to public amenity by providing facilities for the appropriate disposal of used injecting equipment.

According to the *National Needle and Syringe Program Strategic Framework 2010 – 2014* (Commonwealth of Australia, 2011), NSPs aim to "protect the health, social, and economic wellbeing of the community". This is achieved through a priority focus on:

- Blood borne viruses such as HIV, HCV, and HBV (hepatitis B).
- Injecting related injury and disease.
- Facilitating client access to other health and related services.

1.1.1. Service types

In Australia, NSPs can be classified into three types – primary outlets, secondary outlets and pharmacy-based outlets (Commonwealth of Australia, 2011).

Primary NSP outlets are services established for the purpose of providing an extended range of injecting equipment and other services to injecting drug users. Aside from health information, education and referral, they also liaise with a range of local stakeholders including police, local government and other health and community services. The range of services available at each primary NSP outlet may vary depending on local needs and funding.

Secondary NSP outlets operate within an existing health or community service which does not receive specific funding for NSP service provision. Typically, staff at these outlets provide NSP services in addition to the other roles for which they are primarily employed. While some secondary NSP outlets may provide the same range of services as primary outlets, most have limited capacity to provide services other than making sterile injecting equipment and disposal facilities for used injecting equipment available.

Pharmacy-based NSP outlets are community pharmacies that supply injecting equipment and disposal containers to people who inject. In some pharmacies injecting equipment is sold, whereas others provide it free of charge. The provision of NSP services is at the discretion of individual proprietors.

1.1.2. Models of service delivery

NSP services are provided in a range of settings including hospitals, community health centres and pharmacies. They are also provided through a variety of modalities including fixed sites, outreach, and syringe dispensing/vending machines (Commonwealth of Australia, 2011).

Fixed site outlets provide NSP services from a designated building and account for the majority of NSP services in Australia. Typically these services operate during business hours although a small proportion operate 24 hours.

Outreach/mobile outlets increase accessibility of services for hard-to-reach populations who may be unable or unwilling to attend other outlets. Some operate from a vehicle with a small proportion on foot. While some services will respond directly to phone requests for equipment to be delivered, others will travel to designated locations at scheduled times. Typically, these services operate outside of business hours.

Syringe vending machines have been established in all Australian jurisdictions except Northern Territory and Victoria to provide packs of sterile injecting equipment for a small fee. These machines tend to be located within the grounds of an existing health or community service. Some operate 24 hours while others are only accessible once other NSP outlets have closed for the day. Collectively, syringe vending machines contribute to 24-hour accessibility of sterile injecting equipment, and provide alternative points of access for injecting drug users who for a variety of reasons may be reluctant to access face-to-face NSP services.

1.1.3. Future directions

The *National Needle and Syringe Program Strategic Framework 2010 – 2014* (Commonwealth of Australia, 2010) identified a number of priorities for NSPs. These are:

- **Development of national standards to guide NSP practice**. No national benchmarks or processes are currently in place and there is large variability in the way services are provided across Australia. The existence of national standards will ensure "consistent quality of service provision across all services, regardless of service type, modality, location or time of day".
- **Increase the availability of needles and syringes**. Geographical and out-of-business-hours coverage remains a challenge for NSPs nationally. To optimise public health benefits, injecting drug users "need to be able to access NSPs according to need".
- **Improved data collection**. The quality and amount of data collected at NSPs varies across and within jurisdictions. Improving data collection, including the development of a national

minimum dataset for NSPs, would assist with achieving national consistency across jurisdictions and importantly, enable improved service planning and identification of service gaps.

- **Strengthening peer education and involvement**. There is a need to strengthen the evidence base for the involvement of peers in education programs as well as service delivery. "An exploration of models that examine peer education including culturally sensitive service provision to culturally diverse groups should be undertaken."
- **Workforce training**. Training for staff providing NSP services occurs in a variety of ways across jurisdictions. However, there is no national standard that guides the development of training packages to ensure that individuals providing NSP services – in primary, secondary and pharmacy-based outlets – are appropriately trained and skilled. "A nationally consistent approach to workforce training and development would enhance the quality of service provision".
- **Improved referrals to health and welfare services**. NSPs are an important contact for injecting drug users with health and social services. Opportunities for referrals to a range of services "should be available on all occassions of service and be undertaken both proactively and in response to service user request". Improving referral opportunities will involve establishing links with local health services, as well as providing appropriate training to NSP staff.
- **Improved evidence base**. The evidence for the effectiveness of NSPs is substantial. While innovative practice is supported, it is important that service provision is informed by the principles of evidence-based practice. "This means that the best available evidence informs the delivery of services, with practitioners using the best available evidence, moderated by client circumstances and preferences, to improve the quality of clinical judgements and facilitate cost-effective care." Improving the evidence base of NSP will contribute to best practice in the prevention of blood borne virus transmission.

1.2. Needle and syringe programs in the Northern Territory

The Northern Territory NSP (hereafter NT NSP) has been in operation since 1989 (Health Outcomes International, 2002), and is made up of three primary outlets and 10 secondary outlets. It is overseen

by the Sexual Health and Blood Borne Virus Unit of the Department of Health. During 2000 to 2009, the Department provided NSP funding of approximately $5.2 million. The resultant saving in direct healthcare costs avoided through the prevention of HIV and HCV was estimated at $4.2 million (NCHECR, 2010a).

The primary outlets are managed by the Northern Territory AIDS and Hepatitis Council (NTAHC) and are located in Darwin, Palmerston and Alice Springs. Secondary outlets are located at the Centre for Disease Control (CDC)/Clinic 34 in Darwin, Alice Springs, Katherine, Tennant Creek and Nhulunbuy and hospital emergency departments in Alice Springs, Katherine, Tennant Creek and Nhulunbuy. There is also a secondary outlet located at the Yulara Medical Centre at Uluru National Park. (see Table 2). All outlets are fixed site services.

Table 2: Location of NSP outlets in Northern Territory

Location	Primary NSP	CDC/Clinic34	Emergency Department	Other
Darwin	✓	✓		
Palmerston	✓			
Alice Springs	✓	✓	✓	
Katherine		✓	✓	
Tennant Creek		✓	✓	
Nhulunbuy/Gove		✓	✓	
Uluru National Park				✓

Overall, the number of outlets has remained relatively constant since 2002. The volume of sterile injecting equipment distributed through NSPs has been largely stable from 1999 to 2008, with approximately 380,000 sterile needles and syringes distributed on average each year through the NT NSP (NCHECR, 2010a).

Of the 28 pharmacies in the Northern Territory during 2008, 13 were reported to have kits containing sterile needles and syringes for sale (Pharmacy Guild of Australia – Northern Territory Branch, 2008). These are scattered across the Territory, with the majority concentrated in the Darwin area.

The NT NSP is subject to the *Misuse of Drugs Act 1990*. Section 12 of the Act exempts from being an offence the provision of hypodermic needles and syringes by medical practitioners, pharmacists and members of a specified class of persons authorised to do so by the Minister of Justice. Secondary distribution (i.e. from one person to another) is not an offence where the first person can show that s/he obtained the hypodermic needle or syringe from a medical practitioner, pharmacist or authorised class of persons under subsection 12(3) of the Act.

While there is no formal policy document that guides the operation of the NT NSP, a draft policy and guidelines document suggests the aims and objectives of the NT NSP are not inconsistent with those stated in the *National Needle and Syringe Program Strategic Framework 2010 – 2014.* Specifically, the draft states that the aim of the NT NSP is to minimise the transmission of blood borne viruses amongst people who inject drugs, their partners and the broader community.

1.3. Blood borne virus prevalence and injecting risk behaviours

The number of newly diagnosed HIV infections in the Northern Territory decreased from 11 diagnoses in 2008 (NCHECR, 2010b) to seven diagnoses in 2010 (Northern Territory Department of Health, 2011). Of the seven diagnoses in 2010, two were newly acquired (i.e. cases which returned a positive antibody test subsequent to a negative result within one year of HIV diagnosis). There were no cases of HIV transmission among people with a history of injecting drug use during 2010 (Northern Territory Department of Health, 2011). Other sentinel surveillance data suggest that HIV prevalence among injecting drug users in the Northern Territory is below one per cent (Iversen et a., 2011).

The number of newly diagnosed HCV infection in the Northern Territory has remained stable from 2008 to 2010. A total of 212 cases of HCV infections were reported during 2010 (Northern Territory Department of Health, 2011). Sentinel surveillance data indicates that HCV prevalence among injecting drug users in the Northern Territory declined from 2007 to 2009 with an increase during 2010. HCV

prevalence was 62 per cent in 2007, 53 per cent in 2008, 39 per cent in 2009, and 47 per cent in 2010; compared with national prevalence figures of 62 per cent in 2007 and 2008, 50 per cent in 2009 and 53 per cent in 2010 (Iversen et al., 2011).

Sharing of injecting equipment remains one of the more efficient routes of blood borne virus transmission. The percentage of respondents from the Northern Territory in the Australian NSP Survey reporting ever re-using another person's used needle and syringe in the previous month has steadily increased during 2007 to 2009; three per cent in 2007, eight per cent in 2008 and nine per cent in 2009 (Iversen et al., 2011). However, it decreased from 2009 to 2010, with three per cent of respondents indicating that they had ever re-used another person's needle and syringe in the previous month in the 2010 survey. Nationally, the percentage of respondents to the Australian NSP Survey reporting ever re-using another person's used needle and syringe in the previous month was relatively stable (15 per cent – 16 per cent during 2007 to 2009, and 12 per cent during 2010).

While most Northern Territory respondents in the 2010 Australian NSP Survey indicated that they did not re-use other injecting equipment after another person, some reported that they had re-used spoons (27 per cent compared with 21 per cent nationally) and filters (10 per cent of Northern Territory respondents and nationally) in the month prior to the survey (Iversen et al., 2011). Six per cent reported that in the previous month they had been injected by someone else after that person had injected themselves or others, compared with 11 per cent nationally (Iversen et al, 2011).

1.4. Project background and methodology

The Northern Territory Department of Health contracted Anex to undertake a review of the NT NSP. The objective of the review was to assess the effectiveness and efficiency of the NSP in meeting its objectives. Specifically, the review sought to identify:

- The extent to which the objectives of the NT NSP have been achieved; and
- Whether current NSP services represent the most appropriate, effective, and efficient means for achieving these objectives.

The review employed a mixed methods approach. Information was collected from a range of stakeholders across the Northern Territory, including NSP service providers and clients. A complement

of face-to-face and telephone interviews was employed. Interviews were semi-structured (see Appendices 1 – 3 for interview questions). Additionally, a range of quantitative NSP data provided by the Department of Health was analysed.

Consultations were conducted during April and May 2011. Key informants consulted included:

- NSP clients;
- NSP service providers;
- Department of Health representatives;
- Pharmacists;
- Northern Territory Police representatives;
- Alcohol and Other Drugs service providers;
- Local government representatives; and
- Health and welfare non-government service providers.

Consultations with NSP clients occurred over a ten day period using convenience sampling. Fifty NSP clients at the three NTAHC sites at Darwin (17 participants), Palmerston (13 participants), and Alice Springs (20 participants) self-selected to participate in a structured interview of approximately one hour duration. Participants were reimbursed $30 for their time. Demographic and other descriptive information for the participants are presented in Table 3.

Table 3: NSP client consultation - participant information

	N = 50
Sex	
Male	68%

Female	32%
Age	
21 – 25 years	4%
26 – 35 years	20%
> 36 years	76%
ATSI	
Aboriginal/Torres Strait Islander background	36%
Usual source of sterile injecting equipment	(multiple responses)
NTAHC – Darwin	38%
NTAHC – Palmerston	14%
NTAHC – Alice Springs	36%
NSP – other	14%
No response	14%
Drugs most commonly injected	(multiple responses)
Pharmaceutical opioids	78%
Speed	24%
Methadone/Buprenorphine	6%
Steroids	2%
Drugs injected in the last week	(multiple responses)
Pharmaceutical opioids	76%
Speed	18%
Methadone/Buprenorphine	4%
Steroids	2%
Period of injecting	
1 – 5 years	18%
6 – 10 years	14%
11 – 15 years	18%
16 – 20 years	18%
21 – 25 years	18%
> 25 years	10%
No response	4%
NSP/NSP types ever attended	(multiple responses)
NTAHC – Darwin	60%
NTAHC – Alice Springs	42%
NTAHC – Palmerston	40%
Clinic 34/CDC	26%

Emergency Department	38%
Pharmacy	42%

While the sample size is small and should be taken into account when attempting to generalise across all NSP clients, gender and age distribution of the sample were comparable to the Northern Territory sample for the 2010 Australian NSP Survey. The proportion of participants who were of Aboriginal/Torres Strait Islander background was higher than that reported in the 2010 Australian NSP Survey (22 per cent compared to 36 per cent in this sample). Of note is that approximately 40 per cent of the sample had ever attended all outlet types.

> "*This* [the NSP] *is going really really well … it's you know really helped people out. Yeah it's really done good."*
>
> NSP Client, Male (46 – 50 years old)

> *"Sometimes just to talk to someone who knows what you're going through. You learn things that can help, sometimes just settles your mind and makes it easier."*
>
> NSP Client, Male (31 – 35 years old)

> "[Accessed] *All this stuff* [equipment, information and referrals] *really over the years. It's good to have what you need right there and know you can talk if you want to."*
>
> NSP Client, Male (51 years or older)

2. Findings

2.1. Objectives of the NT NSP

There was general agreement among key informants that NSPs have a health protection role, with a focus on reducing the spread of blood borne viruses among people who inject drugs and the broader community. There was also acknowledgement (particularly among service providers and clients) that NSPs have a role in preventing a range of other harms associated with injecting including abscesses and vein damage.

The provision of sterile injecting equipment and safe disposal facilities for used injecting equipment was recognised by key informants as the main strategies by which NSPs fulfilled their role. Providing information on health-related matters generally, and drug-related topics specifically, was acknowledged as an integral part of the NT NSP's function. The potential to refer clients to other health and social services was rarely mentioned by key informants.

2.2. Service delivery model

2.2.1. Types of outlets

NSP services are delivered using a combination of primary and secondary outlets. Similar to other jurisdictions, the extent to which different types of services (equipment distribution, information and education, and referrals) are available across different types of outlets varies (see Table 4). The primary outlets provide the broadest range and depth of services. For example, they may supply a range of injecting equipment compared with the other outlet types, which may only distribute fit kits consisting of needles and syringes, alcohol swabs, and sterile water. Pharmacy-based outlets provide the narrowest range of services. These outlets mainly distribute sterile injecting equipment only on a commercial basis.

As previously indicated, all NSP outlets operate on a fixed-site basis. There are currently no mobile/outreach NSP services in the Northern Territory.

Table 4: Range of services provided by NSP outlet types

	Primary NSP	CDC/ Clinic34	Hospital Based	Pharmacy Based
Equipment Distribution	✓	✓	✓	✓
Disposal of Used Equipment	✓	✓	✓	
Brochures/Pamphlets	✓	✓		
Information/Education	✓	✓		
Support (general conversation)	✓	✓		
Referral information	✓			

2.2.2. *Staffing at outlets*

At the primary outlets at NTAHC, NSP services are mainly provided by staff who have knowledge and experience of injecting drug use and who are specifically employed to provide these services. These staff members are supported by others in their organisation who may be responsible for a range of other projects and programs including the Aboriginal and Torres Strait Islander Project, and the Women's Health, Men's Health, and Sex Worker Outreach Programs.

At the CDC/Clinic34s, NSP services are mainly provided by reception/administrative staff although nurses will also contribute to service delivery. The nurses are more commonly involved in providing health information/referral advice. Service provider interviews suggest that reception/administrative staff spend approximately two hours per week on NSP service provision, including dispensing of sterile injecting equipment, liaising with clients, and preparing fit kits for distribution. Hospital-based outlets provide services via the nurse at the triage desk.

2.2.3. *Hours of operation*

After some experimentation and feedback from clients, the primary NSP outlet in Darwin and Palmerston currently operate from 10:00am to 6:00pm Mondays to Fridays. The primary NSP outlet in Alice Springs operates from 8:30am to 5:00pm. The CDC/Clinic34s are open at approximately 8:00am to 8:30am, and close at approximately 4:00pm to 4:30pm. NSP services at hospital emergency

departments are accessible 24-hours a day, seven days per week; and pharmacies are mostly open during normal business hours.

2.2.4. Equipment supply and distribution

The majority of NSPs order their equipment directly from the Northern Territory Government stores. NTAHC, through its primary NSP outlet in Alice Springs, supplies fit kits to the Alice Springs Hospital Emergency Department and the CDC/Clinic34 in town. NTAHC also supplies fit kits to seven pharmacies in Darwin, one in Katherine and one in Gove. The CDC/Clinic34 in Katherine supplies fit kits to the Katherine Hospital Emergency Department.

A range of sterile injecting equipment is distributed to clients by the primary NSP outlets and the CDC/Clinic34s including fit kits, needles and syringes of various sizes, alcohol swabs, sterile water ampoules, wheel filters and disposal containers of various sizes. Hospital-based NSP outlets only supply fit kits. Fit kits contain five sets of sterile needles and syringes, alcohol swabs, sterile water ampoules, and a personal disposal container. Clients have the option of three types of fit kits – 1ml, 3ml and 5ml – reflecting the size of the syringe in the kit. Pharmacy-based NSPs mostly supply sterile injecting equipment in packs comprising of five 1ml insulin syringes, alcohol swabs, sterile water ampoules, and a personal disposal container.

There are no limits on the numbers of equipment that are distributed per client (except for the Darwin CDC/Clinic34), and there have been instances where clients take boxes of needles and syringes (approximately 100 per box). Due to a lack of storage space, Darwin Clinic34 has a limit of 15 – 20 needles and syringes per person. Except for the pharmacies, sterile injecting equipment is provided free to clients. The primary NSP outlets sell tourniquets and Hirudoid cream which is used to assist with healing of injection sites and to prevent scarring.

2.2.5. Information, education and referral

At the primary NSPs and CDC/Clinic34s, information on a number of health and drug-related topics is available through a range of brochures and pamphlets that are easily accessible by clients. The primary NSPs also conduct health education campaigns on a monthly basis focusing on a particular theme (for example, use of wheel filters). Some opportunistic education is provided through primary and

CDC/Clinic34 outlets as they arise from conversations with clients. Information and referrals are also provided to clients on request.

2.2.6. Disposal of used injecting equipment

The primary NSP outlets and most of CDC/Clinic34s have large disposal bins on premises where clients are able to dispose of their used injecting equipment. Clients are able to return used injecting equipment for disposal by handing them over-the-counter at hospital-based NSPs. In Darwin, there are 15 syringe disposal bins located on premises other than the NSP outlets including at libraries, shopping centres, and public toilets (see Table 5). The primary NSP outlet in Darwin empties the seven disposal bins installed by the Darwin City Council in the CBD on a contractual basis. Pharmacies do not provide disposal facilities. Used injecting equipment is collected by private medical waste management companies under contractual arrangements between these companies and the organisations/agencies where outlets are located.

Table 5: Location of public syringe disposal bins in Darwin

Darwin CBD

- Entrance to Lameroo Beach
- Frogshollow, Lindsay Street side
- Doctors Gully, near Fish Feeding
- Paspalis Centre Exeloo toilet, Austin Lane
- Paspalis Centre, male and female toilets, Austin Lane
- City Library, Civic Centre, male, female and disabled toilets
- West Lane/Vic Arcade, male, female and disabled toilets, and baby change room
- NT AIDS and Hepatitis Council, Wood Street

Darwin Other

- Casuarina Library, disabled toilet
- Rapid Creek Foreshore Exeloo, opposite Beachfront
- Nightcliff Foreshore Exeloo, near Nightcliff pool
- Nightcliff Foreshore Exeloo, near the jetty
- Mindil Beach, high school end, male and female toilets
- Mindil Beach, Casino end, male, female and outside toilets
- Water Gardens in Jingili, outside the toilets
- Hibiscus Shopping Centre, disabled toilet

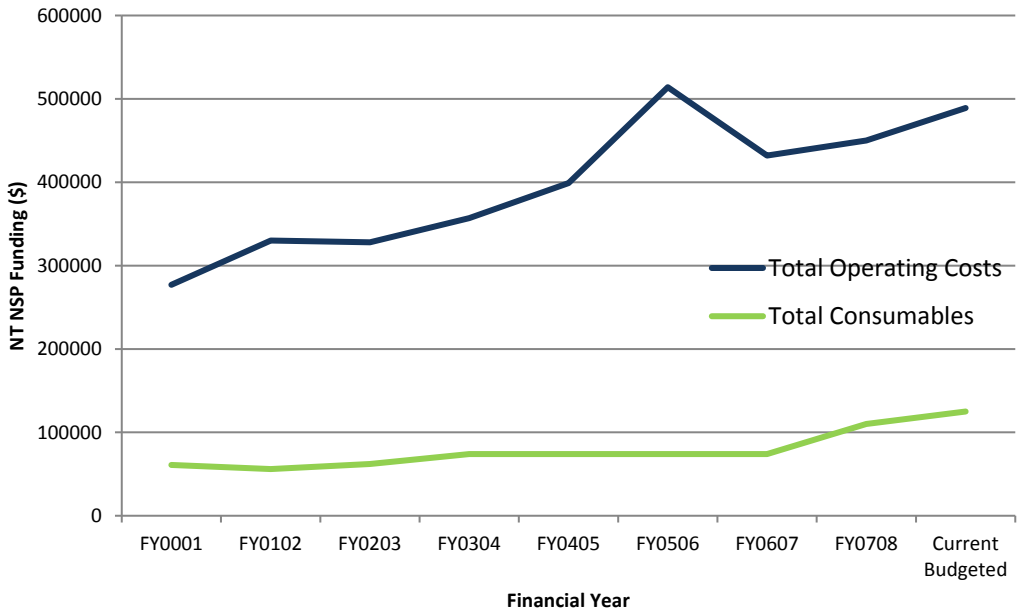
Source: Darwin City Council

2.3. Operating costs

The Department of Health estimates that annual operating cost for the NT NSP is approximately $489,000. Additionally, approximately $125,000 is provided for the supply of sterile injecting equipment. Funding provided to NTAHC for NSP service provision (not including cost of consumables) has been relatively stable since July 2007. Funding by the Department of Health accounts for 60 per cent of NSP operating costs at NTAHC, with the remaining 40 per cent of NSP operating costs funded by the Commonwealth Department of Health and Ageing.

As illustrated in Figure 1, funding for the NT NSP by the Department of Health over eight years showed an increasing trend from FY2000/01. Funding for consumables has remained largely stable with a slight increase from FY2006/07 to present.

Figure 1: NSP funding by Department of Health

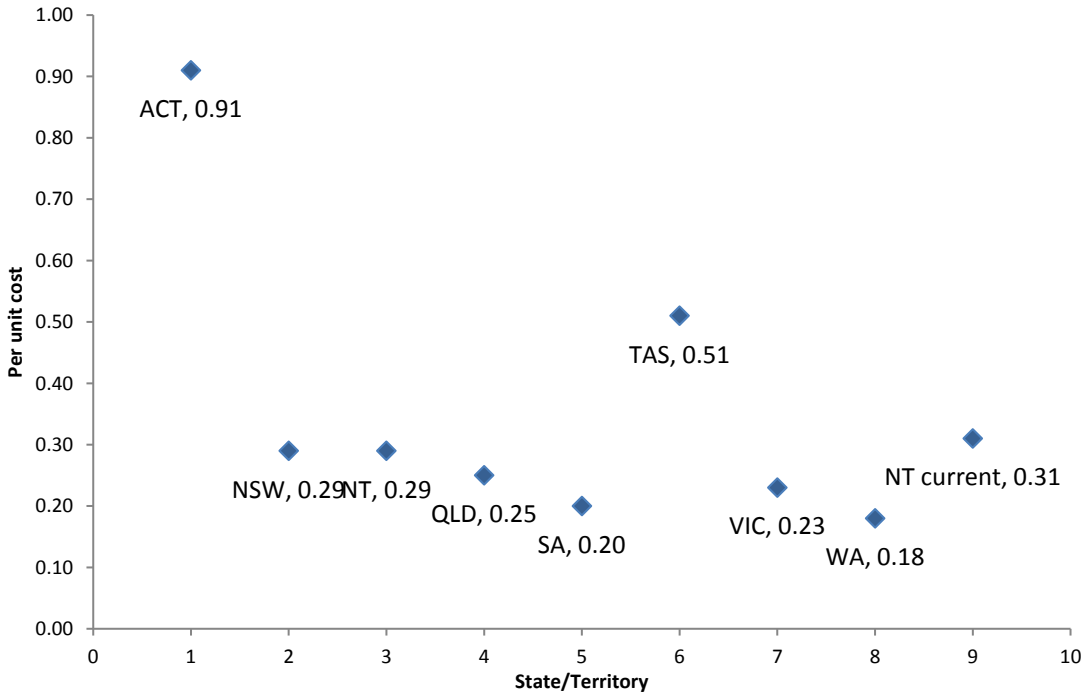


Source: NCHECR (2010a) and Department of Health

A comparison of per unit cost for consumables across Australian jurisdictions was undertaken using data from the *Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe*

programs in Australia (NCHECR, 2010a). Per unit costs were calculated using the reported expenditure on consumables divided by the average number of sterile injecting equipment distributed per year. As Figure 2 illustrates, the per unit cost for consumables in the Northern Territory (both current per unit cost based on data analysed for this review and as reported in the *Return on Investment 2* study) is comparable to that of most other jurisdictions.

Figure 2: Per unit cost of consumables across Australian states and territories



Source: NCHECR (2010a)

"I try to stock up decent stockpile at home so that when people drop by there's no need to borrow."

NSP Client, Male (41 – 45 years old)

"Oh well these have been here - the Needle Exchange [NSP] *- and everything's on hand and like I say I get enough when I come up … a hundred of tips and a hundred barrels."*

NSP client, Male (46 – 50 years old)

"I don't so much set out to [pick up equipment for others] *but I always make sure I have got it there because no doubt someone will want it so yeah … I have got a few friends that work out in the mines and they come into town and they've got nothing; so I know they're going to show up at some stage."*

NSP Client, Female (31 – 35 years old)

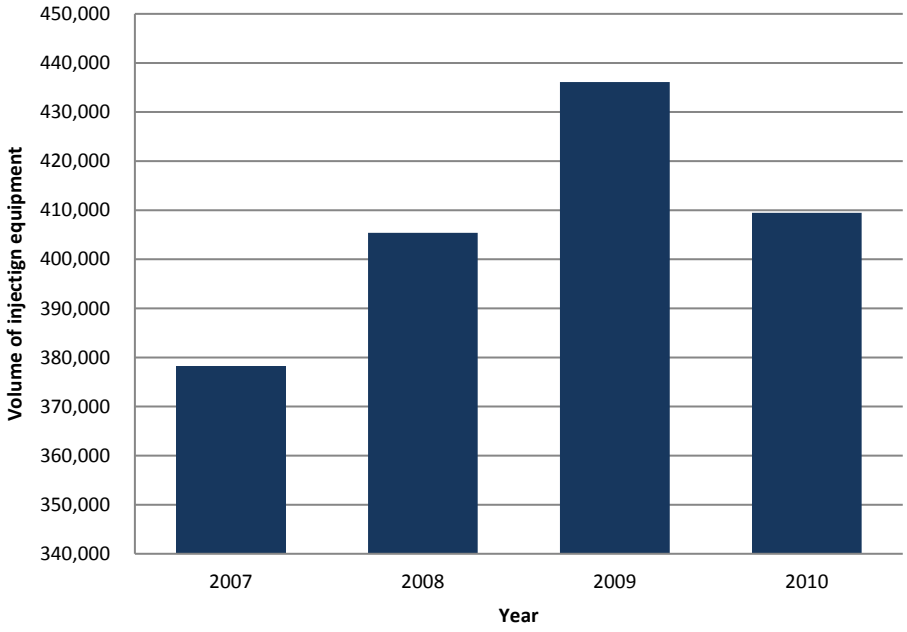
2.4. NT NSP outputs

2.4.1. Equipment distribution

From 2007 to 2010, NSP outlets distributed an average of 407,292 needles and syringes per year (an increase of approximately seven per cent from the average volume of distribution reported in the *Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia* (NCHECR, 2010a)). The primary NSP outlets distribute the highest volume of sterile injecting equipment, with the Darwin and Palmerston primary NSP sites accounting for approximately 82 per cent of the total volume of sterile injecting equipment distributed during 2010. Among secondary NSP outlets, the CDC/Clinic34 in Katherine and the Alice Springs Hospital Emergency Department reported the highest volume of sterile injecting equipment distributed during 2010.

The volume of equipment distributed increased from 2007 to 2009 (see Figure 3). Volume of equipment distributed in 2010 was six per cent less compared with 2009. Factors accounting for the recent decline in numbers of sterile injecting equipment are unclear considering that funding for consumables show a general upward trend. Data from the primary NSP outlets indicate that the number of clients reporting being from rural or other areas declined by approximately 53 per cent in 2010 compared with 2009 (see section 2.5.2) which might account for the decrease in volume of injecting equipment distributed given that clients from rural areas may be more likely to require larger volumes of equipment.

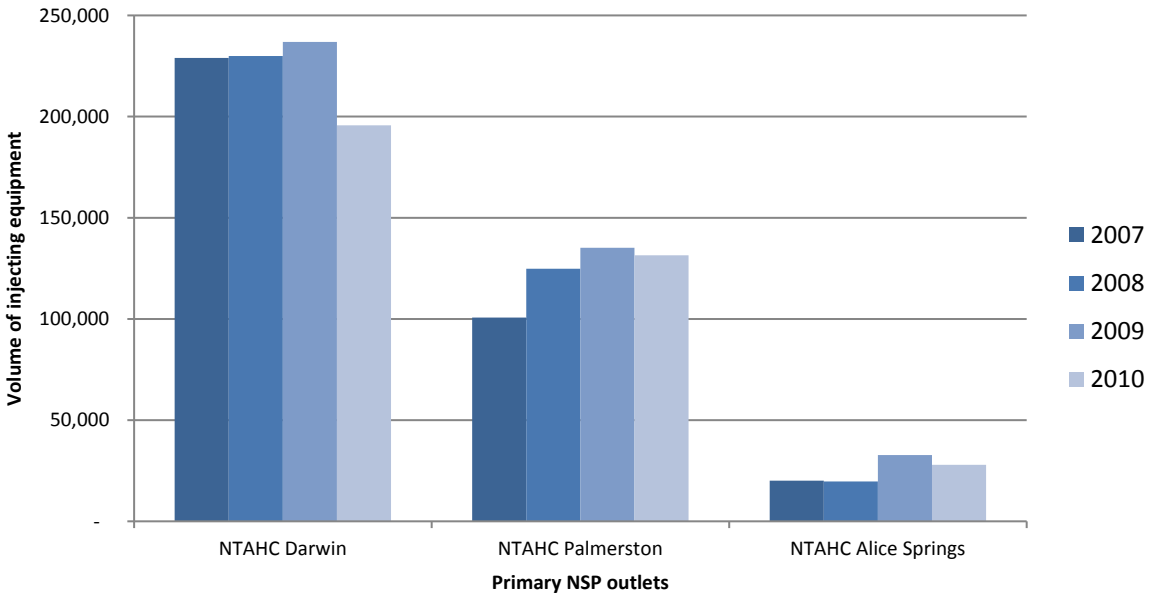
Figure 3: Volume of equipment distributed by NSP outlets (2007 - 2010)



Source: Department of Health

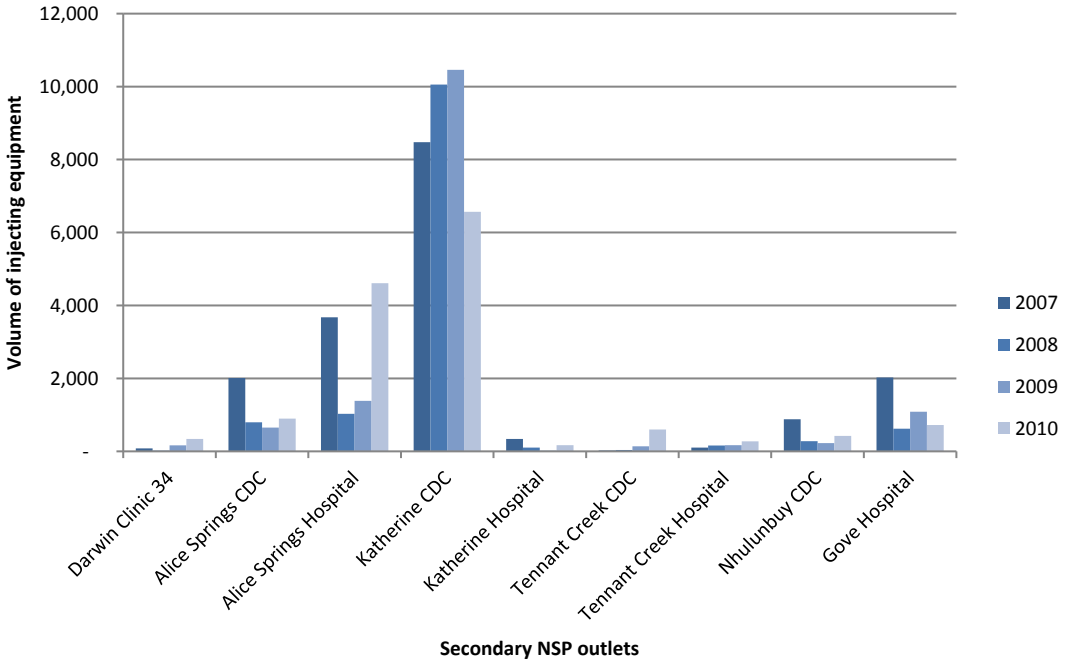
Decreases in equipment distribution were predominantly reflected in the reduced outputs of the primary NSP outlets, and to a lesser extent, the CDC/Clinic34 in Katherine and Gove Hospital (see Figures 4 - 7). Volume of equipment distributed through the primary NSP outlets decreased by 12 per cent. All other outlets reported an increase in the numbers of equipment distributed. Data for Tennant Creek CDC/Clinic34 showed that volume of equipment distributed in 2010 was three times more than in 2009, and data for the Alice Springs Hospital Emergency Department showed that volume of equipment distributed doubled during this period. The results for the secondary NSP outlets should be interpreted with some caution as the four-year trends in volume of equipment distributed vary as illustrated in Figure 5 and may reflect quality of data reporting rather than actual changes in outputs.

Figure 4: Volume of equipment distributed by primary NSP outlets (2007 - 2010)



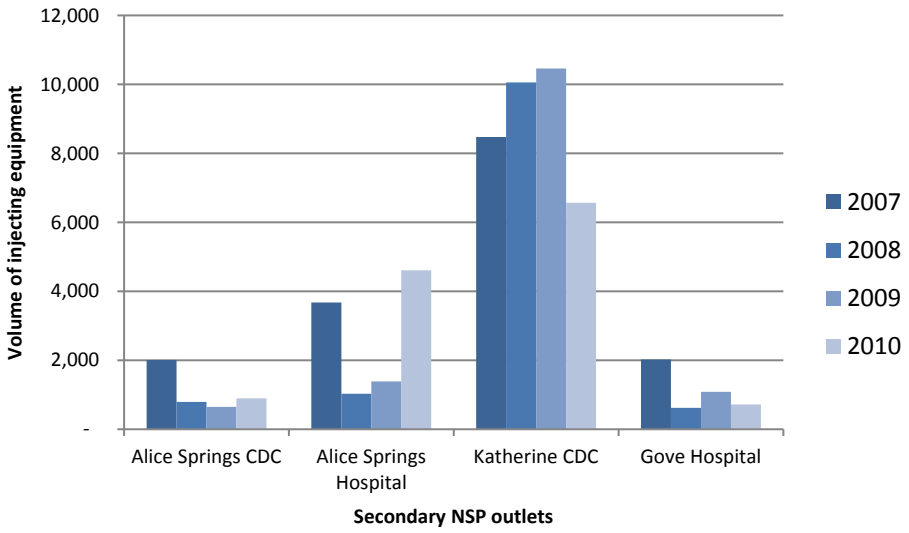
Source: Department of Health

Figure 5: Volume of equipment distributed by secondary NSP outlets (2007 - 2010)



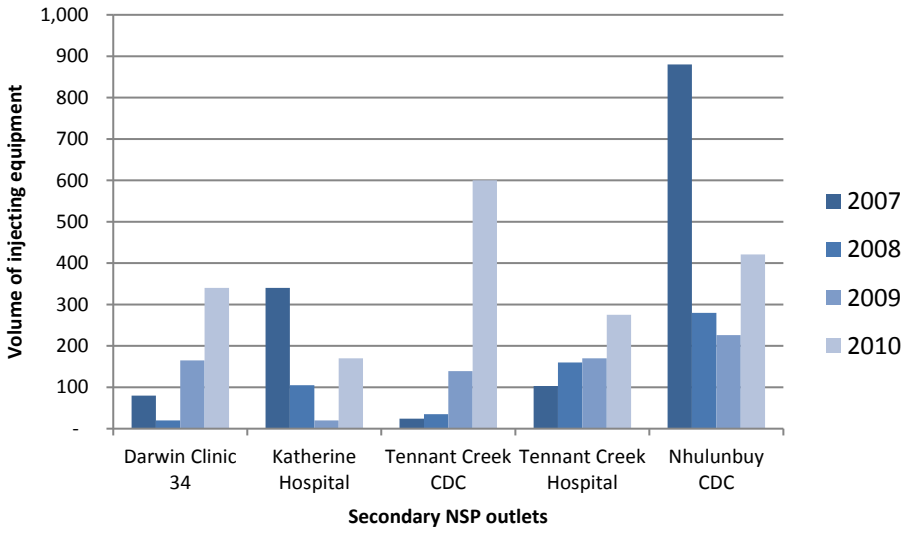
Source: Department of Health

Figure 6: Volume of equipment distributed by four highest secondary NSP outlets (2007 - 2010)



Source: Department of Health

Figure 7: Volume of equipment distributed by five lowest secondary NSP outlets (2007 - 2010)



Source: Department of Health

The majority of sterile injecting equipment distributed was in Darwin, followed by Palmerston and Alice Springs. Equipment distributed in Tennant Creek and Nhulunbuy represented a small percentage of the total number of equipment distributed in the Northern Territory. As illustrated in Table 6, the proportion of equipment volume in each region relative to total equipment distributed was relatively stable from 2007 to 2010.

Table 6: Equipment distributed by location as a percentage of total equipment distributed by year (2007 – 2010)

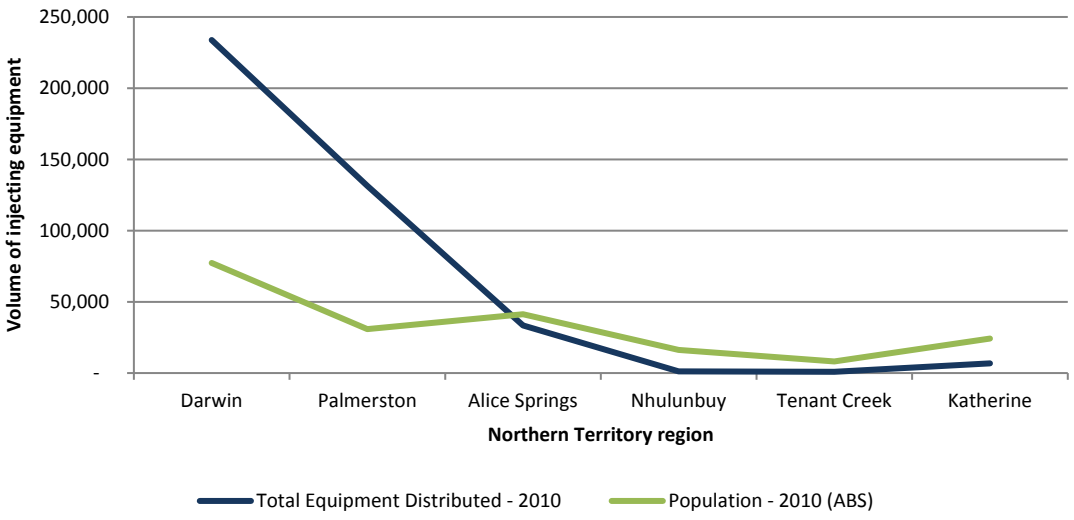
	2007	2008	2009	2010
Darwin	63%	61%	58%	57%
Palmerston	27%	31%	31%	32%
Alice Springs	7%	5%	8%	8%
Katherine	2%	3%	2%	2%
Nhulunbuy	1%	<1%	<1%	<1%
Tennant Creek	<1%	<1%	<1%	<1%

Source: Department of Health

1. Data from secondary NSP was missing for some years for some locations. Distribution trends for these outlets indicate that the missing data would have minimal impact.

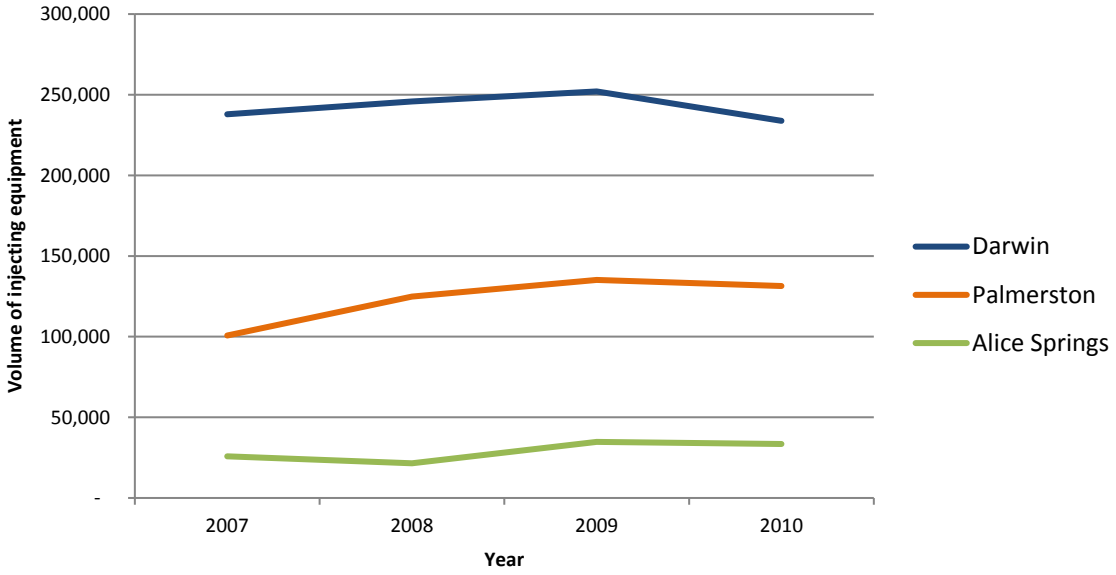
As Figure 8 shows, except for Darwin and Palmerston, the volume of sterile injecting equipment distributed across all locations during 2010 was largely consistent with population distribution within the Territory. The results for Darwin and Palmerston are not surprising as injecting drug use tends to be more prevalent within cities compared to regional and rural areas.

Figure 8: Volume of equipment distributed and population distribution across each region



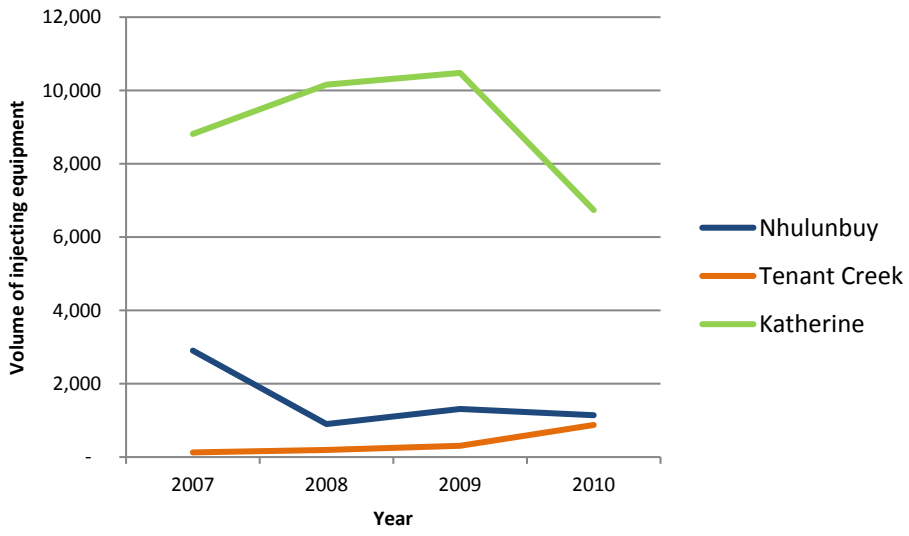
Volume of equipment distributed in Darwin and Katherine showed an appreciable decrease between 2009 and 2010, however volume of equipment distributed at all other locations remained relatively stable (see Figures 9 and 10).

Figure 9: Volume of equipment distributed in urban regions (2007 - 2010)



Source: Department of Health

Figure 10: Volume of equipment distributed in regional areas (2007 - 2010)



Source: Department of Health

"I have had a lot … had a bit to do with this place for the last few years, so yeah I know I can ask for whatever I want – any sort of information, anything like that … like I said information about hep C and anything like that ... information about different drugs and stuff like that."

NSP Client, Male (36 – 40 years old)

"Peer information is good but sometimes I would like to talk to a qualified person but not a straight suit type person. Peers just talk about their own experiences, not backed up by current research or wider knowledge. It is tricky though 'cause you don't want the peer rave but neither do you want a straight."

NSP Client, Female (26 – 30 years old)

2.4.2. Episodes of health education/information

NSP clients who were interviewed for the evaluation were asked if they ever attended each of the NSP outlet types in the previous six months, and if so, if they have ever been provided with health information and education at these outlets. Results are reported in Table 7, indicating that outlets based within hospital emergency departments and pharmacies have limited capacity to do so. The finding coincides with information gathered from key informant interviews.

Table 7: Received health information and education at each outlet type ever attended in the previous six months

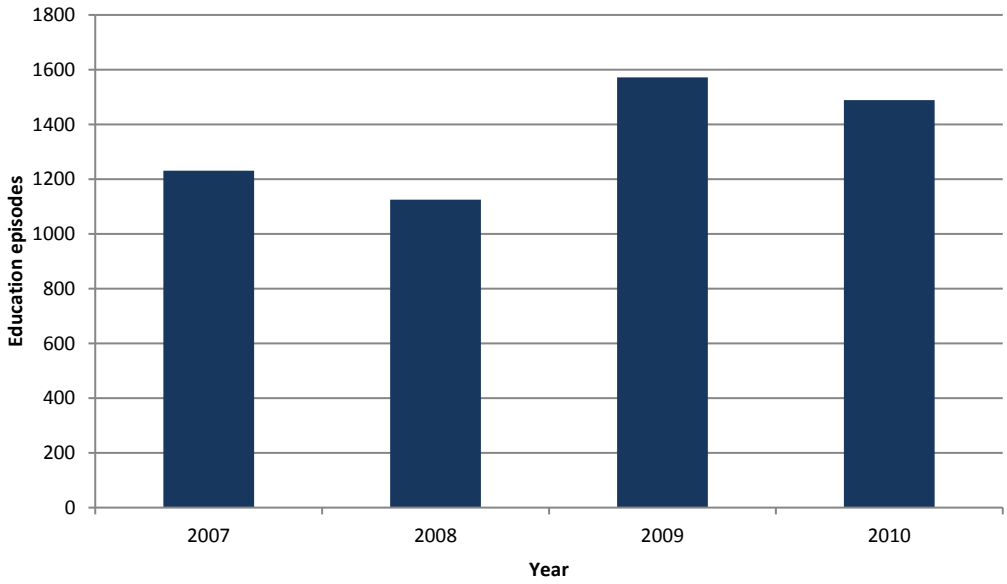
NTAHC – Darwin (n = 30)	11(37%)
NTAHC – Alice Springs (n = 21)	3 (14%)
NTAHC – Palmerston (n = 20)	8 (40%)
Clinic 34/CDC (n = 13)	1 (8%)
Hospital Emergency Department (n = 19)	0
Pharmacy (n = 21)	0

Information collected through service provider interviews highlighted the importance of providing education on filtering due to the high numbers of clients reporting injecting pharmaceutical opioids. The harms associated with steroid use, and safer injecting of steroids was also nominated as a key health issue, particularly at the Darwin Clinic34 which had a predominantly steroid using clientele.

Data on episodes of health information and education provided by all NSP outlets is not systematically collected across all outlet types. Only the primary NSP outlets report on health information and education provided to clients. During 2010, a total of 1,489 episodes of health information and education were reported across the three primary outlets. The most common topics were morphine, opioid substitution therapy, safer injecting, and filtering pills. These were followed by information/education on steroids, hepatitis, HIV/AIDS, and mental health.

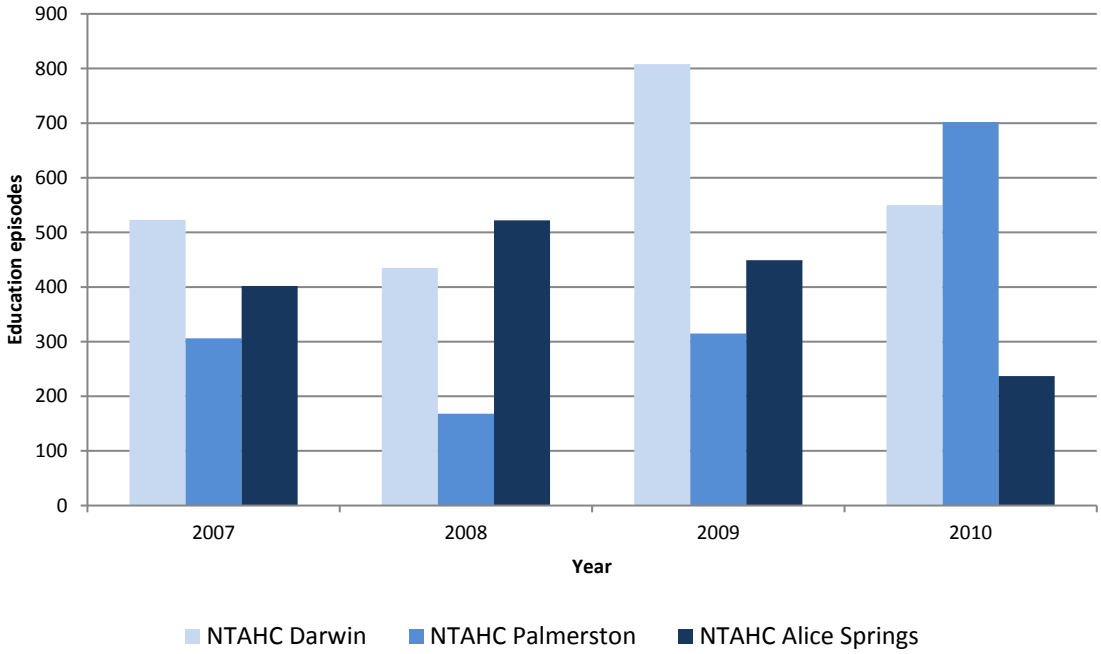
A trend analysis of health information and education episodes for the primary NSP outlets was undertaken. As illustrated in Figure 11, the number of health information and education episodes showed an increasing trend from 2008 to 2009 and was relatively stable from 2009 to 2010. The decline in episodes of health information and education appear to be driven by declines at the Darwin and Alice Spring sites (see Figure 12).

Figure 11: Education episodes at primary NSP outlets (2007 - 2010)



Source: Department of Health

Figure 12: Education episodes at each primary NSP outlet (2007 - 2010)



Source: Department of Health

> *"Clinic 34 referral for bloods. Coconut Grove referral for advice on housing and benefits. Also got advice on heroin withdrawal, and pregnancy termination."*
>
> NSP Client, Female (26 – 30 years old)

> *"I had a slack moment and shared* [injecting equipment] *once so they referred me to 34* [Clinic34] *for bloods* [blood test] *and it worked out okay. I'm clean, but it freaked me out. I'll never share again no matter what."*
>
> NSP Client, Male (41 – 45 years old)

> '[They referred me to] *Palmerston Clinic to look at my hands."*
>
> NSP Client, Female (36 – 40 years old)

> "[Have the NSP ever given you information about other services or agencies that you might want to visit?] *Yeah … I think it was there with welfare and kids being taken away from the family and because I would have been prescribed by the doctor pain killers and suddenly I am a street junkie in their eyes."*
>
> NSP Client, Male (41 – 45 years old)

2.4.3. Referral episodes

NSP clients who were interviewed for the evaluation were asked if they ever received (i) information about another health service or agency, or (ii) assisted referral to a health service or agency when they

visited each outlet type in the previous six months. As indicated in Table 8, referrals mainly occurred in the primary NSP outlets. Referrals are also more likely to involve providing information about a health service or agency rather than providing assistance to access a health service or agency.

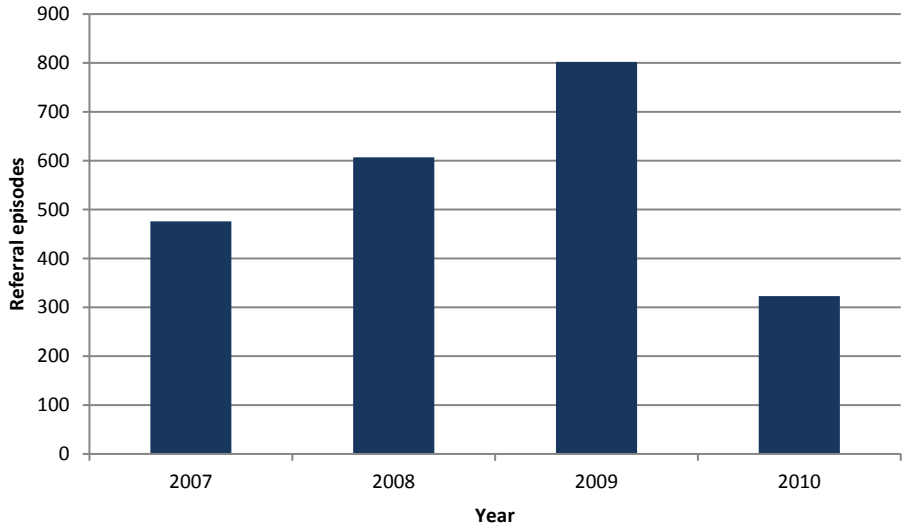
Data on referral episodes is only collected by the primary NSP outlets. During 2010, a total of 341 referral episodes were reported. Common referrals reported were to mental health services, and internal referrals to a range of other programs offered by NTAHC (Sex Workers' Outreach Project, Aboriginal and Torres Strait Islander Project, and Women's Health Project). Referrals to general practitioners and other alcohol and drug services were also common although less frequent. Anecdotal information collected through service provider and client interviews indicated a wide range of services to which clients are referred. These include housing assistance, community legal services, and the CDC/Clinic34 for blood borne virus testing and sexual health issues.

Table 8: Received information about another health service or referral at each outlet type ever attended in the previous six months

Information about another health service or agency	
NTAHC – Darwin (n = 30)	10(33%)
NTAHC – Alice Springs (n = 21)	3 (14%)
NTAHC – Palmerston (n = 20)	9 (45%)
Clinic 34/CDC (n = 13)	1 (8%)
Hospital Emergency Department (n = 19)	0
Pharmacy (n = 21)	0
Referral	
NTAHC – Darwin (n = 30)	6(20%)
NTAHC – Alice Springs (n = 21)	1 (5%)
NTAHC – Palmerston (n = 20)	3 (15%)
Clinic 34/CDC (n = 13)	1 (8%)
Hospital Emergency Department (n = 19)	0
Pharmacy (n = 21)	0

A trend analysis on referral episodes across the three primary outlets showed that there was an increasing trend from 2007 to 2009, with a significant decline in referral episodes during 2010 (see Figure 13). The decrease in numbers of referral episodes was reported across the three primary outlets.

Figure 13: Referral episodes at primary NSP outlets (2007 - 2010)



Source: Department of Health

> *"I know what's on offer so it's a good deal. It takes away the worry sometime just knowing if there is a problem I know they will help me sort it out."*
>
> NSP Client, Male (41 – 45 years old)

> *"Why they wouldn't* [access the primary NSP outlet]*? F**d if I know mate, it's private here you know what I mean, like you go into a hospital and you go and get a fit pack … whether you're putting it inside your jumper or whatever like that, people don't see you and they go and give you filthy looks. At least you come here people know what we're coming here for."*
>
> NSP Client, Male (36 – 40 years old)

2.5. NSP clients

2.5.1. Number of NSP visits

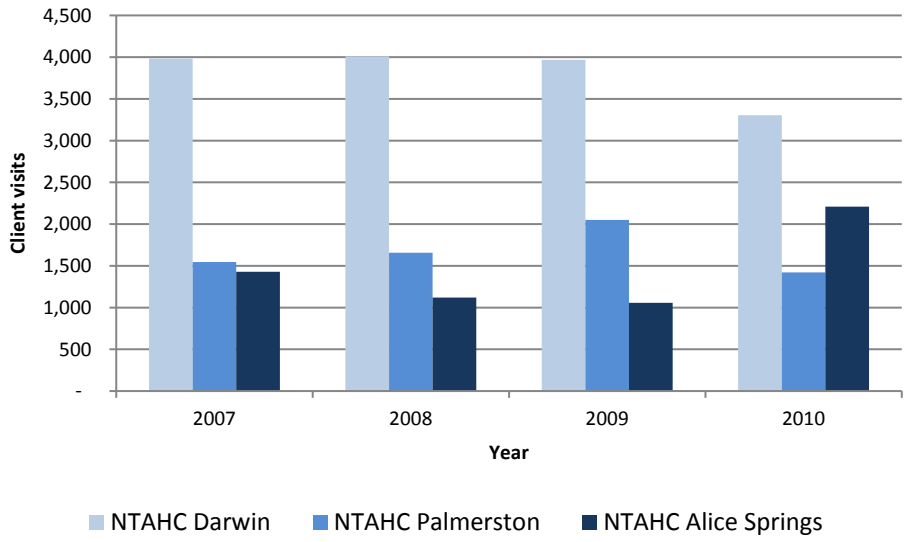
The primary NSP outlets have the highest number of attendees. During 2010, the three primary NSP outlets recorded a total of 6,935 visits. Data from the Department of Health indicate that the number

of NSP visits at the three primary outlets during 2010 ranged from approximately 180 per month at Alice Springs to 275 per month at Darwin.

Client demographic information is collected at most secondary NSP outlets except for pharmacies. However, there are reported issues with the robustness of the information collected and there is no centralised collation of the information reported. Anecdotal information from services interviewed suggests that secondary NSP outlets service between four to 20 clients per month. Service providers did not report any significant changes in the numbers of clients attending their NSP. The volume of sterile injecting equipment sold at pharmacies has increased between 2009 and 2010, however it is not known how many individuals access them to purchase injecting equipment.

As illustrated by Figure 14, total number of client visits across the three primary sites was relatively stable during the 2007 – 2009 period. Number of client visits at the Alice Springs primary NSP site doubled from 2009 to 2010, although volume of equipment distributed declined during this period. There was a slight decrease (17 per cent) in the number of client visits at the Darwin primary NSP, while the number of client visits during 2009 to 2010 decreased by approximately one third at the Palmerston site. It was unclear what factors contributed to the differences in number of client visits across the period.

Figure 14: Number of NSP client visits by primary NSP outlet (2007 - 2010)



Source: Department of Health

2.5.2. *Client profile*

As reported in Table 9, during 2010 more males attended the three primary NSP outlets than females, and the majority of visits were by clients aged 36 years and over. Approximately 15 per cent of client visits were by people of Aboriginal/Torres Strait Islander background. People from rural areas accounted for approximately seven per cent of client visits. Drug last injected was usually pharmaceutical opioids (morphine), with the injection of speed reported in about a third of client visits.

Interviews with service providers indicated that the profile is largely consistent across NSP outlets, i.e. Anglo-Australian males who use pharmaceutical opioids. Speed use was reported as sporadic and dependent on a variable supply, and heroin use was reported to be almost nonexistent. Interestingly, the Darwin CDC/Clinic34 reported that the majority of their clients are steroid users.

Table 9: Client demographics across primary NSP outlets in 2010

	N = 6935
Sex	

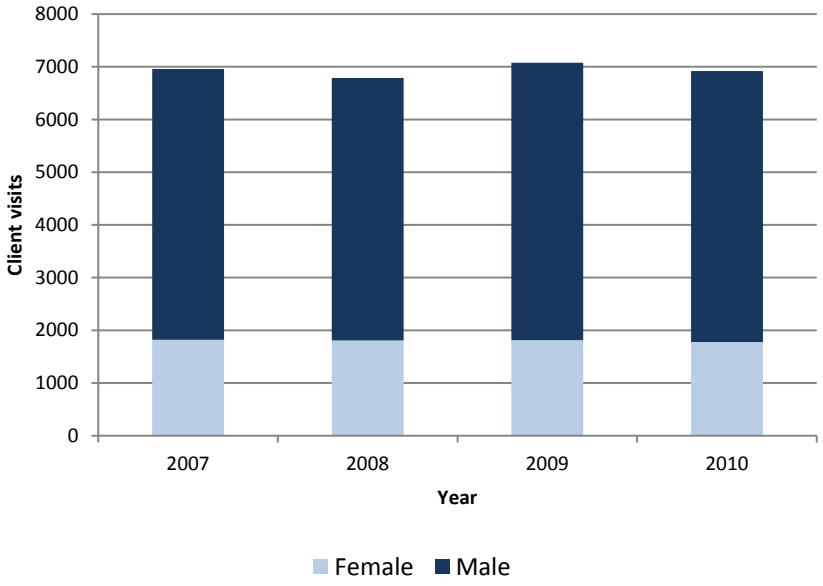
Male	74%
Female	26%
Age[1]	
25 years and under	9%
26 – 35 years	38%
36 years and over	54%
ATSI	
Aboriginal/Torres Strait Islander background	15%
Rural/Other	
Rural/Other	7%
Drug Last Injected[1]	
Morphine	51%
Speed	35%
Methadone	7%
Steroids	6%

[1] Rounding error

Source: Department of Health

A trend analysis of client visits at the primary NSP outlets showed that the number of client visits by gender and the proportions of male versus female clients was stable during 2007 – 2010 (see Figure 15).

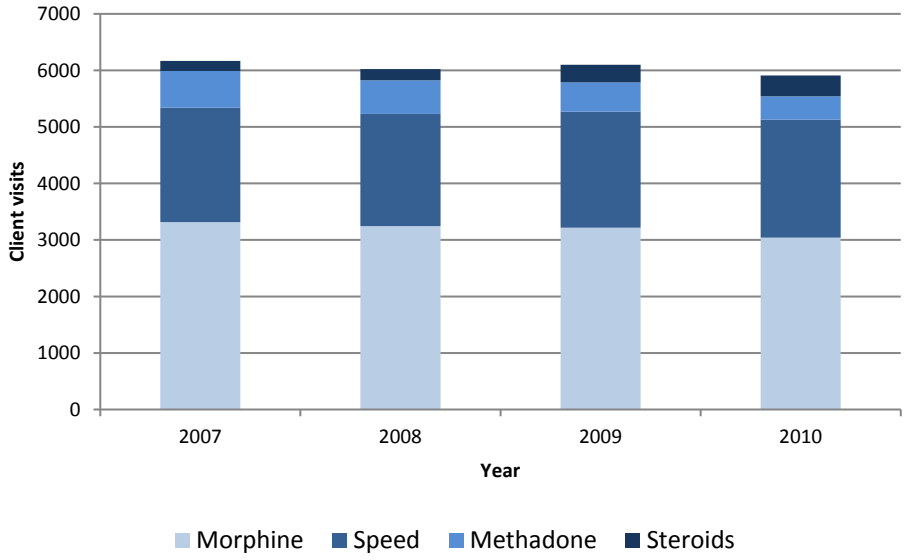
Figure 15: Proportion of male vs female client visits at primary NSP outlets (2007 – 2010)



Source: Department of Health

The number of visits by type of drug last injected and proportions of reported use of various drugs also remained stable during this period (see Figure 16). While they represented a small proportion of the total number of client visits, the proportion of steroid injectors has increased during this period (3 per cent in 2007; 3 per cent in 2008; 5 per cent in 2009; 6 per cent in 2010). Differences in proportion of client visits by steroid injectors across the four years was statistically significant (X^2 (3) = 106.2, $p < .01$), but pairwise comparisons for client visits for each year using the Marascuilo Procedure recommended by Levine, Stephan, Krehbiel, & Berenson (2010) were unable to detect significant differences between years.

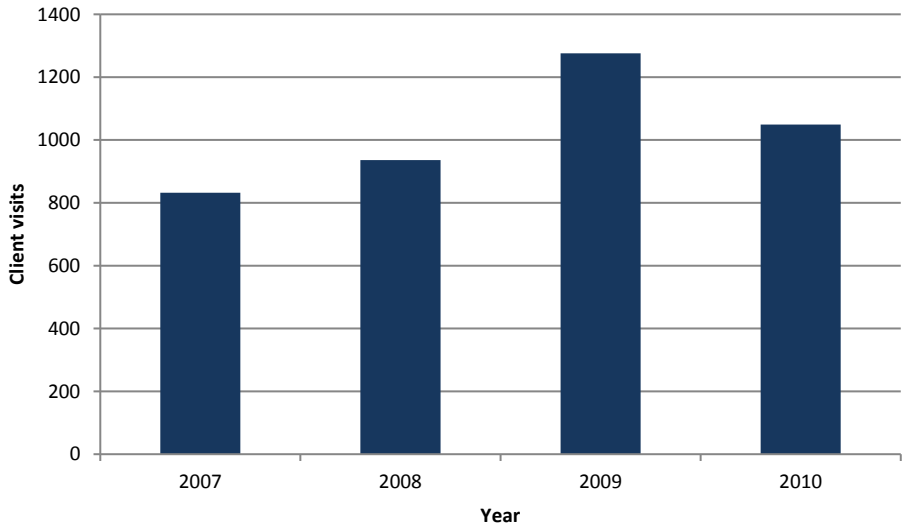
Figure 16: Reported drug last injected for client visits at primary NSP outlets (2007 - 2010)



Source: Department of Health

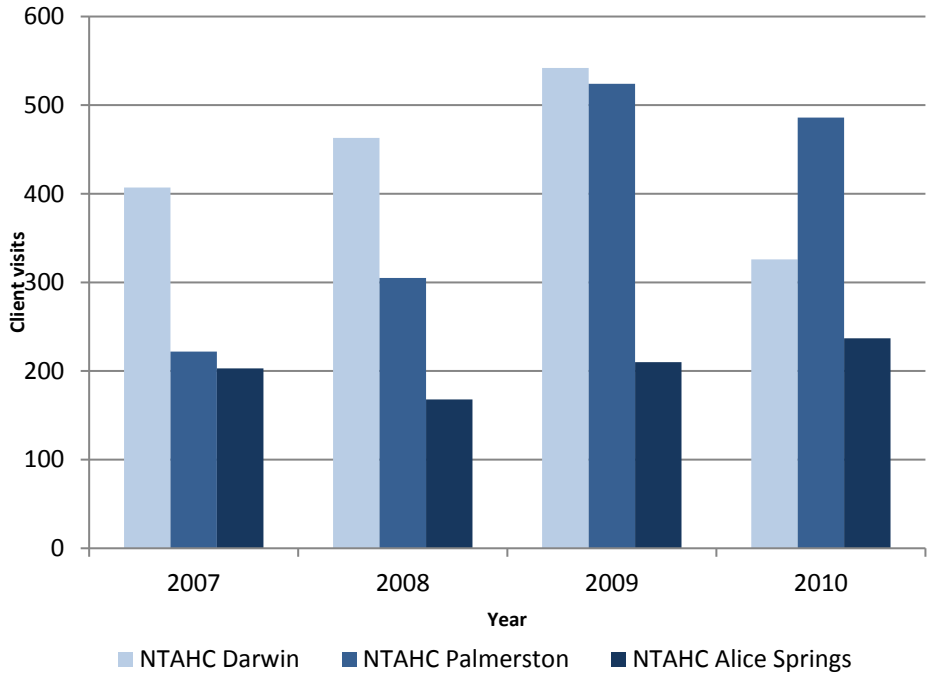
Visits by clients of Aboriginal/Torres Strait Islander background across the three primary NSP sites increased from 2007 to 2009, with a subsequent decline during 2010 (Figure 17). The increase across this period was statistically significant (X^2 (3) = 109.5, p< .01), and was largely attributable to client visits at the NTAHC Darwin and Palmerston sites (Figure 18).

Figure 17: Number of visits at primary NSP outlets by clients of Aboriginal/Torres Strait Islander backgrounds (2007 - 2010)



Source: Department of Health

Figure 18: Number of visits by clients of Aboriginal/Torres Strait Islander backgrounds at each primary NSP outlet (2007 to 2010)



Source: Department of Health

Aboriginal/Torres Strait Islander client visits represent a small proportion of total number of client visits (see Table 10). Pairwise comparisons detected significant differences in the proportion of visits by Aboriginal/Torres Strait Islander clients during 2007 and during 2009.

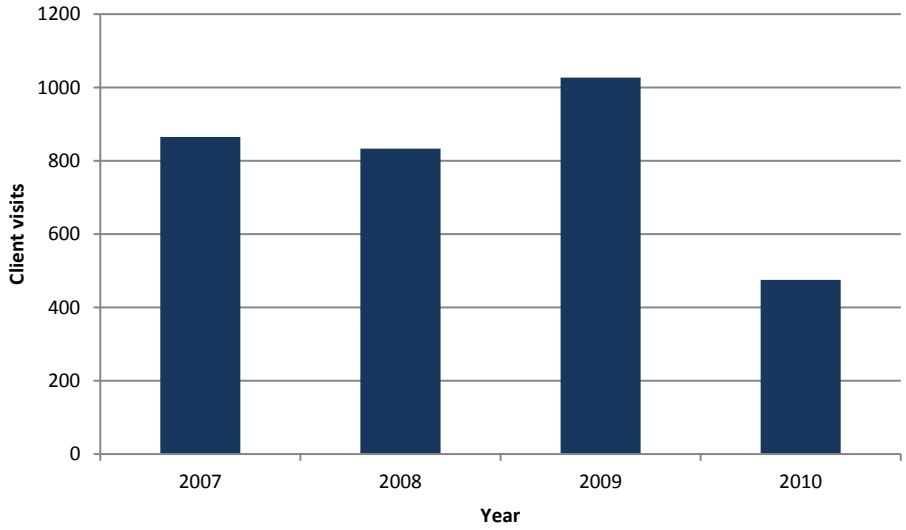
Table 10: Proportion of visits at primary NSP outlets by clients of Aboriginal/Torres Strait Islander background (2007 - 2010)

	2007	2008	2009	2010
Darwin	10%	12%	14%	10%
Palmerston	14%	18%	24%	22%
Alice Springs	12%	13%	18%	17%
Total	11%	13%	18%	15%

Source: Department of Health

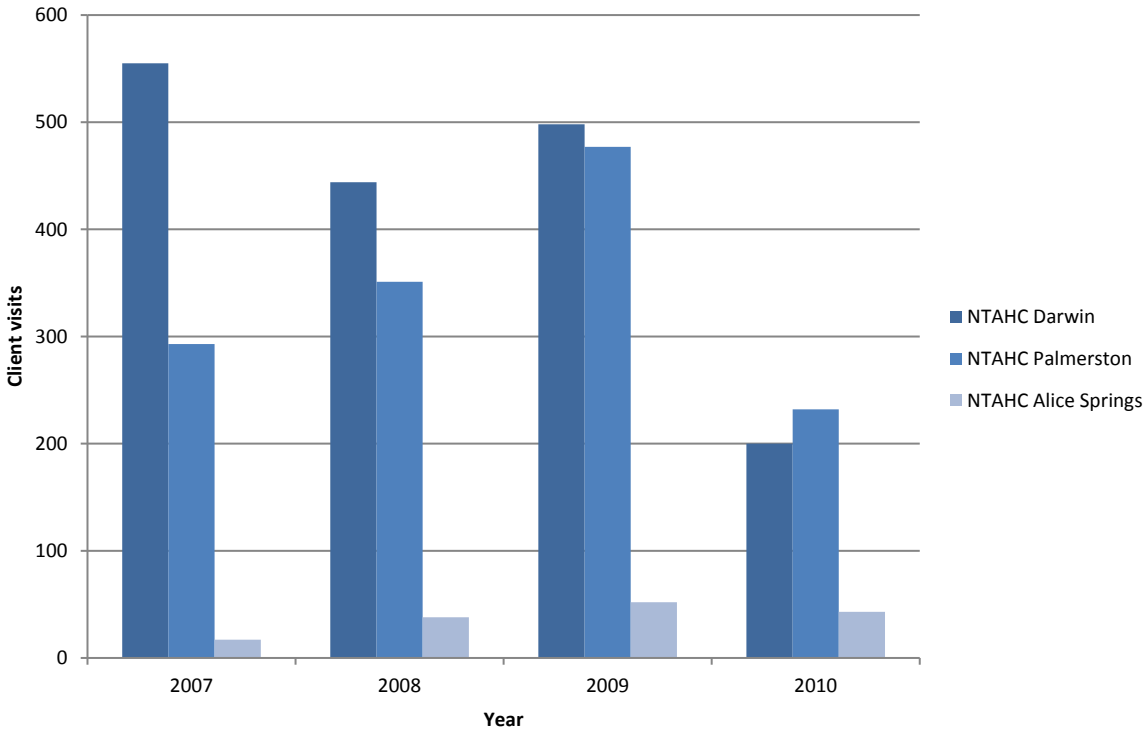
Number of visits by clients indicating that they were from rural or other locations increased from 2007 to 2009, with a subsequent decline in 2010 (see Figure 19). As illustrated in Figure 20, the decline was mostly attributable to the NTAHC Darwin and Palmerston sites. Visits by clients reporting being from rural or other locations as a proportion of total client visits was relatively stable from 2007 to 2009, but declined during 2010 (12 per cent during 2007 and 2008; 15 per cent during 2009; and 7 per cent during 2010). Changes in visits by clients from rural or other locations were statistically significant (X^2 (3) = 220, $p < .01$), but pairwise comparisons showed that this was largely attributed to the decline in client visits during 2010.

Figure 19: Number of visits at primary NSP outlets by clients from rural or other locations (2007 - 2010)



Source: Department of Health

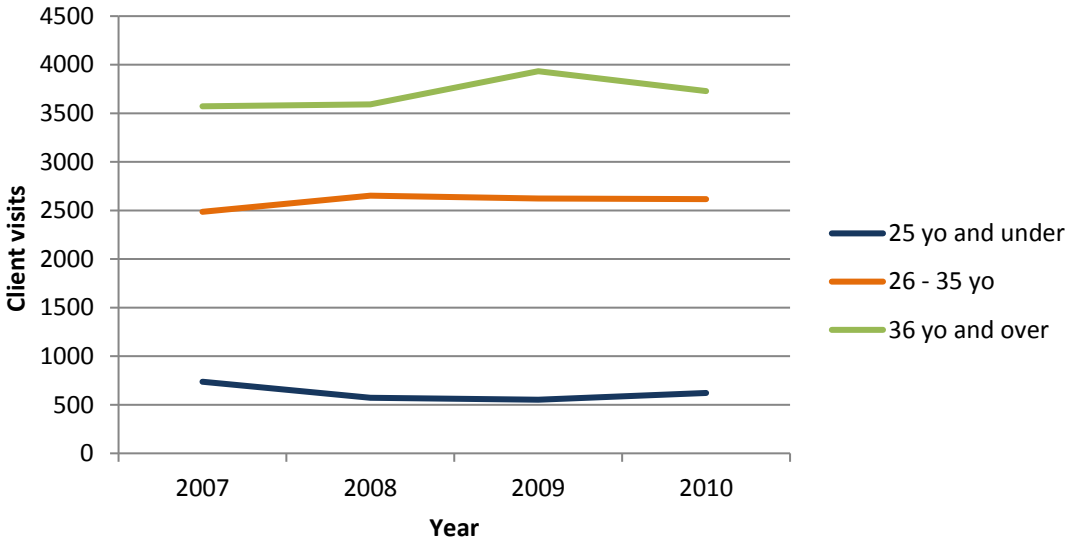
Figure 20: Number of client visits from rural or other locations by primary NSP outlet (2007 - 2010)



Source: Department of Health

As illustrated in Figure 21, number of client visits at the primary NSP outlets between 2007 and 2010 among the 25 years and under, and 26 – 35 years age groups has remained stable. Client visits by people aged 36 years and older represented a little more than half of total client visits. Change in the number of client visits in the 36 years and older age group across the four years was statistically significant (X^2 (3) = 13.7, $p < .01$) but pairwise comparisons were unable to detect where the differences were. Proportion of client visits for each age group was stable across the four year period (see Table 11).

Figure 21: Client visits by age group at primary NSP outlets (2007 - 2010)



Source: Department of Health

Table 11: Clients within each age group as a proportion of total number of clients (2007 – 2010)

	2007	2008	2009	2010
25 years and under	11%	8%	8%	9%
26 – 35 years	37%	39%	37%	38%
36 years and over	53%	53%	55%	54%

Source: Department of Health

"Well if I was just coming straight in and out to pick up gear probably about five minutes. [But that may vary because…] *Get into conversations with staff about various things or questions."*

NSP Client, Male (41 – 45 years old)

"No, they're okay. They're good to talk to about stuff. Sometimes they are really busy but I usually get time to talk outside in the garden."

NSP Client, Male (41 – 45 years old)

"Outside coffee here in the yard. It's nice with the trees, you can sit and have a smoke."

NSP Client, Male (41 – 45 years old)

2.5.3. Use of services

Responses on the use of NSP services by the 50 NSP clients interviewed are reported in Table 12. The majority of respondents (46 per cent) indicated that they visited NSPs to access sterile injecting equipment on a monthly basis. Others commonly visit the NSP on a weekly basis (38 per cent) and only two per cent reported accessing the NSP on a daily basis. Disposal facilities at NSPs were used with equal frequency – weekly or monthly – by most of the respondents. Average time spent at the NSP during each visit may range from one minute to more than 10 minutes, with the majority reporting spending an average of 5 minutes or more at the NSP.

Consistent with service provider reports, respondents mostly accessed larger barrel syringes (3ml and 5ml) and a range of single needles. Aside from sterile needles and syringes, most respondents reported accessing sterile water ampoules, alcohol swabs and disposal containers. Of note is that between 76 to 78 per cent of respondents indicated that they have recently or ever injected pharmaceutical pill-based opiates, but only 32 per cent reported accessing wheel filters which are a more effective means for filtering out chalk and other impurities compared with other filtering tools such as cotton wool.

Approximately 40 per cent of respondents indicated that they had accessed other services at the NSP in the six months prior to the interview. Of the 30 respondents who have done so, half had accessed information about a health topic, which was commonly through speaking with an NSP worker and through accessing or being given printed information. Just over a quarter (26 per cent) had accessed information about another health service or agency, and just under a quarter (23 per cent) had been referred to another health service or agency.

Twenty-seven respondents indicated that they had ever been assisted by the NSP to access another health service or agency. All of these respondents indicated that they were satisfied with the process. Most interactions between staff and clients at NSP appear to be initiated by clients as the results of Table 12 show.

Table 12: Use of NSP services reported by NSP client consultation participants

	N = 50
Access of NSP for Sterile Injecting Equipment	(Multiple responses)
Daily	2%
Few Days	10%
Weekly	38%
2 – 3 weeks	8%
Monthly	46%
Access of NSP for Disposal	(Multiple responses)
Daily	2%
Few Days	4%
Weekly	32%
2 – 3 weeks	6%
Monthly	54%
Average time spent at NSP	(Multiple responses)
Less than 1 minute	4%
1 – 5 minutes	46%
5 – 10 minutes	32%
More than 10 minutes	30%
Type of Equipment Usually Access	(Multiple responses)
1ml insulin syringe	30%
3ml syringe	52%
5ml syringe	32%
10ml syringe	6%
Other syringe	8%
25g needle	34%
26g needle	18%
27g needle	38%
Other needle	12%
Alcohol swabs	86%
Sterile water ampoules	78%
Wheel filters	32%
Cotton	28%
Other	10%

Personal disposal container	6%
1.8ltr disposal container	34%
8 ltr disposal container	30%
Disposal container (unspecified)	10%
Information/Education and Referral in last six months	(Multiple responses)
Information about health topic	30%
Information about another health service	16%
Referral to another health service	14%
None	60%
Mode of Information/Education	n = 11
Verbal	9%
Printed	18%
Both	73%
Ever talked to an NSP worker about problem	
Yes	62%
Who started the conversation?	n = 36
Self	69%
Staff	31%
Referrals Ever Received	
NSP provide information about another health service	48%
NSP helped get into another service	54%
Satisfaction with referral process	n = 27
Very satisfied	56%
Satisfied	41%
Quite satisfied	4%
Not satisfied	0%
No response	7%

Other reasons that respondents reported for attending NSPs include access to counselling, or just to have a chat. Respondents were asked what would make it easy or difficult to talk to an NSP worker about a problem they may have. As shown in Table 13, staff attitudes were a significant factor in

determining whether clients will engage with an NSP worker. A physical environment that is conducive to talking to staff, and privacy and confidentiality concerns were also highly rated factors that were considered by respondents.

Table 13: Factors that impact on client engagement with NSP staff

	N = 50
What makes it easier for you to talk to NSP staff about a problem	(Multiple responses)
Staff attitudes – friendly, interest, openness, nonjudgemental	80%
Space to sit and be comfortable	40%
Private space to discuss problem	32%
Other	16%
No Response	12%
What makes it difficult for you to talk to NSP staff about a problem	(Multiple responses)
Staff attitudes – unapproachable, uninterested, judgemental	50%
Busy/Crowded Space	26%
Lack of privacy	32%
Other	8%
No Response	30%

2.6. Linkages and partnerships

2.6.1. Linkages between NSPs

There are strong links between the primary NSP outlets and the secondary outlets in Darwin and Alice Springs. In Darwin, the relationship between the primary outlet and the CDC/Clinic34 appeared robust, as evidenced by awareness among staff at each site of the others' operations, and reciprocal referrals to and from each other. There appeared to be some communication between the CDC/Clinic34 at Katherine with the primary outlet in Darwin – the new reception/administrative staff attended half-day training at the primary where they were shown how the primary outlet operates. The primary NSP is also available for secondary consultation by staff at the CDC/Clinic34 in Katherine.

As previously mentioned, the primary NSP outlet in Alice Springs supplies fit kits to the CDC/Clinic34 and the Alice Springs Hospital Emergency Department. There is regular liaison between staff at these

outlets, although given the nature of the CDC/Clinic34 with its primary focus on blood borne viruses and sexually transmissible infections, the relationship between the primary outlet and the CDC/Clinic34 is stronger. There was relatively less communication between the NSPs in Tennant Creek and at Nhulunbuy.

2.6.2. Linkages with other agencies

In Darwin and Palmerston, the primary NSP outlets have regular meetings with Tobacco, Alcohol, and other Drugs Services (TADS) which provides pharmacotherapy and withdrawal services. They are also linked in with a range of other nongovernment organisations such as Amity Community Services which supports people with alcohol and other drug issues, and the Larrakia Nation Aboriginal Corporation which provides services to homeless/houseless Indigenous people living in and around Darwin ("Long Grass People"). The primary NSP outlet in Darwin has formal linkages with local government, and there are plans both at the NTAHC NSP site at Darwin and Palmerston to engage with local government on expanding the availability of public syringe disposal bins.

In Alice Springs and Katherine, formal linkages between NSP outlets and other agencies were not reported. In Tennant Creek and Nhulunbuy service providers tend to know each other given the size of the population.

From the service provider interviews, it would appear that the police in each of the regions where NSPs operate are generally supportive of the NT NSP. Anecdotal reports indicate that there are generally few problems in relationships with police although there are no formal linkages established.

2.7. Staff professional development

Professional development for NSP staff is available through the Department of Health Alcohol and Other Drugs Program which has an accredited training package that was designed to meet the requirements of a specific unit of competency within the National Community and Health Services Training Package (i.e. the equivalent of the current CHCAOD407C: Provide Needle and Syringe Services). The training package was developed by NTAHC during 2005 as part of a Commonwealth-funded NSP Workforce Development Project. The accredited course comprised a face-to-face training workshop over two days,

and a self-learning manual that was designed to complement the material in the workshop. There was also an option of a one day workshop for participants who did not seek to be assessed under the unit of competency.

Two workshops (one of two days duration, and the other a one day workshop) were held during 2005 and attended by staff from a range of organisations, including those that did not provide NSP services. However, while the information supplied by the Department of Health indicated that the workshops were effective in improving participants' knowledge and confidence in providing NSP services, it was unclear to what extent participants completed the course and were assessed. Since then, no further training workshops have been held. According to key informants consulted, the Alcohol and Other Drugs Program were reluctant to deliver the training workshops unless there were at least between six to eight participants.

Staff at the primary NSP outlets are required and supported to obtain minimal qualifications in Certificate III Community Services Work, with some staff holding qualifications or completing their qualifications, in Certificate IV Alcohol and Other Drugs. The Certificate III Community Services Work is directed at building staff competence in a range of areas including working with clients to identify presenting needs, and to provide support to clients using one-on-one and group formats including making accurate referrals. Staff attain competencies in working with alcohol and other drug issues under the Certificate IV Alcohol and Other Drugs including assessing client needs, providing support to clients with mental health and alcohol and other drugs issues, providing interventions for people with alcohol and other drug issues, and undertaking case management for clients with complex needs.

For secondary NSP outlet staff, it appeared that training and workforce development occurred through a combination of on-the-job learning and spending at least half a day at a primary NSP outlet to observe how NSP services are delivered. However, from the consultations, it appeared that only the CDC/Clinic34 secondary outlets in Darwin and Katherine have done so and feedback indicated that it was a useful exercise.

Key informants had mixed views as to whether formal qualifications were required. However, as a minimum the following topic areas were identified as being relevant – (i) understanding the rationale

for NSP services, (ii) knowledge of the types of drugs that are commonly injected and their implications for service delivery, and (iii) understanding of the potential issues faced by clients and their needs.

2.8. Issues and challenges

> *He gets it* [injecting equipment] *off other people who go to the Council because he's of the opinion that there's cameras here and every time he goes near the place they take photos and that of him approaching the building as well and they get those photos and stick it up in the police lockers so that they know who to look out for in the street."*
>
> NSP Client, Male (41 – 45 years old)

> *"A lot of them don't they keep the same barrel and they might change the tip but the barrel they use four or five times and I mean there's a lot of bacterial left in that barrel and I said 'Look, f***n, it's only up the road mate, if you can't go up the road and get clean gear you've got a car, you've got this, you've got that'. 'Oh I'm not a junkie'."*
>
> NSP Client, Male (46 – 50 years old)

> *"I did go in there* [pharmacy] *and buy, I mean I have gone in and bought five mil barrels and said they're for the cat, the kids or whatever and that's all fine. But as soon as you want a five mil barrel to use it's … yeah, different story."*
>
> NSP Client, Female (31 – 35 years old)

2.8.1. Client access

Improving access to NSP services for people who inject drugs was identified as a priority by key informants. It was recognised that there were sub-populations of injectors who were not accessing the NT NSP. Among them are the "Long Grass People" who are mostly of Indigenous background who do not (temporarily or permanently) have housing. Other sub-groups include women and younger aged injectors who might not be accessing NSP as often as men and those in older age groups. People living in rural or remote communities and Indigenous Australians generally were also identified as priority groups.

Close to half of the respondents to the NSP client interviews (46 per cent) indicated that they were acquainted with people who do not access NSP outlets and more than half (56 per cent) indicated that when they picked up sterile injecting equipment at NSPs, they were also picking up for others. There was some overlap between the two groups of respondents although it was not a straight forward correspondence. For example, those who picked up injecting equipment for others might know more

people who do not access NSPs than the people they were picking up for. Some respondents who might know of others who did not access NSPs may not be picking up injecting equipment for others.

Respondents who reported knowing others who do not access NSP and those who picked up sterile injecting equipment for others indicated that the number of people ranged from one to eight, with one respondent indicating that he knew 30 people residing in a remote community who do not access the NSP. The majority of respondents who picked up injecting equipment for others indicated that they did so for one or two people. The respondent who knew 30 people who do not access NSPs reported picking up injecting equipment for those 30 people.

Respondents who picked up injecting equipment for others were distributing it to close to 100 people. Even discounting the respondent who was picking up for 30 people, the findings indicate that for each person accessing the NSP, there are approximately two others who do not access the NSP but have others pick up injecting equipment for them. None of the respondents suggested that people who did not attend NSPs shared injecting equipment. They indicated that they may have sourced sterile injecting equipment from friends or dealers, or they may have purchased injecting equipment at pharmacies. Reasons for nonattendance include, people being lazy, fear of police harassment, being identified as an injecting drug user, distance, and being unable to afford public transport.

An issue that impacts on injecting drug users' access to NSPs is real or perceived stigma. Service providers indicated that accessing pharmacies or hospital emergency departments for sterile injecting equipment may be very intimidating for some people. Reasons include the risk of being identified by members of the community as an injecting drug user because one is accessing sterile injecting equipment in an exposed environment, staff negative attitudes about drug users, and the time it might take before being served which may increase anxiety about exposure as a drug user. Respondent feedback on the various outlet types was generally positive for the primary NSP outlets and the outlets at CDC/Clinic34s. Comments regarding hospital emergency department NSPs were more varied, with some respondents providing positive comments and others stating that they would only utilise the NSP at hospitals as a last resort. Respondents were clearer in their reluctance to access pharmacy-based NSPs. Issues include attitudes of staff, fear of exposure as a drug user to community members, being

identified by the dispensing pharmacist and jeopardising their place in the opiate pharmacotherapy program because they were using drugs, and having to purchase equipment.

> *"Yes, this is the one* [Darwin primary NSP] *I go to every time. They are friendly and know their stuff. Always helpful. It's in the centre of town so* [is] *easy to get to. Palmerston is too far away."*
>
> NSP Client, Female (26 – 30 years old)

> *"Yeah well I usually don't have a car so* [to get to the NSP] *it's either with these guys or another girlfriend."*
>
> NSP Client, Female (31 – 35 years old)

> *"… the hospital is miles away. Clinic 34 would be closed on the weekend too, I'd say. So you know the hospital is miles away from where I live, it would be a pain in the arse* [to go there]*. Like I try and make sure I have got shit* [injecting equipment] *on me."*
>
> NSP Client, Male (36 – 40 years old)

> "[What are some reasons people don't pick up equipment from NSPs?] *Bus takes too long … it's too much trouble."*
>
> NSP Client, Female (36 – 40 years old)

2.8.2. Accessibility of services

As previously indicated, distance was nominated as a possible reason that some people might not be accessing NSPs. Two suburbs in Darwin (Nightcliff and Coconut Grove) were identified by service providers as being potential locations where sub-populations of injecting drug users might reside, some of whom might not be accessing NSPs. While it was acknowledged by key informants that it is not inconvenient to take public transport into the CBD where the majority of NSPs are located, there may be other factors that deter people from doing so. These include being unable to afford public transport, and carrying large volumes of injecting equipment which might single one out as a drug user.

After-hours and weekend access was also identified as an issue by key informants. While hospital emergency departments in other locations do provide access to sterile injecting equipment when other NSP outlets are closed, the Royal Darwin Hospital does not operate an NSP. In Darwin, pharmacies provide the only option for after-hours and weekend access to sterile injecting equipment. One pharmacy in the outer suburbs of Darwin is open until 10:00pm on Mondays to Fridays, and from 9:00am to 9:00pm on weekends and public holidays.

Among respondents to the NSP client interviews, the majority (94 per cent) agreed with the statement that "it is very easy for me to get to an outlet no matter where I am". When asked if they had ever been unable to access sterile injecting equipment when they needed it, 44 per cent described an occasion when that had occurred. Ten of the 22 respondents who were unable to access sterile injecting equipment when they needed it indicated that it was because the NSP was closed because it was after-hours, or on a weekend or public holiday. None of the respondents indicated that they shared injecting equipment. The common response was to re-use their existing injecting equipment.

The majority of respondents reported that it took between 10 to 30 minutes from their home, and from their source of drugs, to get to an NSP (see Table 14). It ought to be noted, however, that these are clients who are attending NSPs, and generalising the finding to others who do not attend NSPs should be done with caution. In terms of distance clients may potentially have to travel to get to an NSP, it should be noted that for approximately one third of respondents (30 per cent) the distance between the NSP and home was more than 30 minutes. For approximately one third of the respondents (32 per cent) the distance between the NSP and where they sourced their drugs was more than 30 minutes.

Table 14: Distance from NSP

	N = 50
Home	
1 – 10 minutes	16%
10 – 30 minutes	50%
30 – 40 minutes	18%
> 40 minutes	12%
No response/Not sure	4%
Source of drugs	
1 – 10 minutes	8%
10 – 30 minutes	40%
30 – 40 minutes	18%
> 40 minutes	14%

Varies 10 – 60 minutes	8%
No response/Not sure	12%

"No I don't pick them [wheel filters] *up; find them a waste of time, when you've got cotton wool. I reckon you lose – oh well that's just my opinion – but I reckon you lose more of the mix with the wheel filters so I use, yeah, cotton."*

NSP Client, Male (36 – 40 years old)

"More education on wheel filters – especially the colours. And training not just pamphlets."

NSP Client, Female (46 – 50 years old)

2.8.3. Pill filtering and injection-related infections and injuries

An issue pertinent in Darwin, Alice Springs and Katherine was the filtering of crushed opiate-based pills. While wheel filters are provided at no cost to clients at the primary NSP outlets in Darwin and Alice Springs, and at the NSP outlet in Katherine, service providers indicated that their uptake was minimal. Service providers expressed concern that NSP clients were therefore not filtering their pills appropriately which may lead to serious health complications. Service providers at these sites reported that they had seen clients with scars, ulcers and abscesses, although none of the service providers indicated that the incidence was high. Among the 32 NSP clients interviewed in Darwin and Palmerston, six had had fingers amputated.

Service providers observed that injectors' attitudes toward the use of wheel filters were extremely polarised. Those who do use wheel filters were very positive about their use, whereas those who don't were very entrenched and adamant that they would not do so. The main reason that injectors will not use wheel filters was the perception that some of the drug in the mix will be left on the filter and therefore wasted.

2.8.4. Steroid use

Steroid use was identified as an emerging issue by a number of service providers in Darwin. While the data collected from the Darwin and Palmerston primary NSPs showed a steady increase of steroid users

accessing these NSP outlets, and the Darwin CDC/Clinic34 reported that the majority of their clients were steroid injectors, the extent of steroid injectors' access to NSP is unclear. Anecdotal reports from service providers in Darwin suggest that there may be significant numbers of people who are injecting steroids who may have limited knowledge of the harms associated with steroid use, and how to minimise these harms. One service provider gave an account of a male client who was injecting steroids for the first time and had expected to use a 1ml insulin syringe which was inappropriate for that purpose. Another reported a young female client who had been provided with an unsealed half full vial of steroid who mistakenly thought that she should inject the steroids intravenously[1]. The NSP worker had to educate her on injecting steroids safely.

> *"Because I have been on the program out there like four times. You turn up once a bit glary eyed or whatever and they say 'look no we're not dosing you today that's it'. So what do I do? I am on the Su*boxone*. 'You won't dose me so I am going to go out and get me fucken own,' I said."*
>
> NSP Client, Male (46 – 50 years old)

> *"If you are on methadone or whatever and you go in* [to the pharmacy] *for gear* [injecting equipment] *you can get yourself identified and struck off for a few weeks. It's not worth it."*
>
> NSP Client, Female (26 – 30 years old)

> *"Not really except for the fact that if you had to cash your* [pharmacotherapy] *scripts there* [the pharmacy] *then they know what you're up to and that would obviously unofficially get back to your doctor* [pharmacotherapy prescriber]."
>
> NSP Client, Male (41 – 45 years old)

2.8.5. Access to pharmacotherapy

Limited access to pharmacotherapy services can have an impact on NSP. In Darwin, there are long waiting lists to get on the opiate pharmacotherapy program. Patients are dosed at the Royal Darwin Hospital for the first two weeks before they are allocated to a community pharmacy. The Royal Darwin Hospital only provides dosing services between 10:00am and 12:00pm each day. The hospital is located in the northernmost suburb of Tiwi. Getting to the hospital on time may be an issue for some clients because of distance. Key informants reported that there is a standing policy that if a patient is suspected

[1] Steroids are administered via intramuscular injection.

of being intoxicated, the hospital or community pharmacist may decide that the patient not be dosed. There is also a policy that if a patient has misbehaved in any way, that patient may not be dosed for three days. When the three days have expired, the patient is expected to undergo a drug test (urinalysis) and is eligible to continue with the program only if the drug test is negative. While the operation of the opiate pharmacotherapy program is beyond the scope of this evaluation, it is noted in this report that potentially, there may be NSP clients who experience difficulties with being on the opiate pharmacotherapy program, and who may need support to do so.

2.8.6. Public disposal of used injecting equipment

Syringe litter was reportedly not an issue in the Northern Territory, and service providers noted that the incidence of inappropriately discarded used injecting equipment in public places was extremely low. Service providers indicated that promoting appropriate disposal of used injecting equipment is one of the key education topics at NSPs. Nonetheless, service providers reported that there were clients who were not disposing of equipment appropriately (e.g. in glass jars instead of syringe disposal containers).

A parallel issue was the provision of more public syringe disposal bins. There are eight public syringe disposal bins within Darwin CBD, and an additional eight bins located outside Darwin CBD. Service providers within Darwin indicated that more should be installed to improve accessibility to disposal facilities. Service providers in Alice Springs and Katherine also indicated that increasing the number of publicly accessible syringe disposal bins was a priority.

3. Assessment

3.1. Service delivery model

The general NSP service delivery model adopted in the Northern Territory with its reliance on a range of primary, secondary and pharmacy outlets is comparable to that of other jurisdictions and is consistent with current practice within Australia. Provision of the range of NSP services available (equipment distribution, information and education, and referrals) is largely borne by the primary NSP sites, which is not unusual and is also consistent with NSP service delivery in Australia. While acknowledging that there are significantly fewer secondary NSP outlets in the Northern Territory compared with other jurisdictions, an encouraging departure from current national practice is that the majority of secondary NSP outlets as represented by the CDC/Clinic34s do provide information and education for clients including access to printed materials and opportunistic education. Of note is that situating an NSP within organisations such as NTAHC and the CDC/Clinic34s has enabled significant value adding to the operations of the NT NSP. Clients are able to access a range of other programs and services that are offered by these organisations including brief counselling and primary care.

It was noted however that the types of organisations delivering NSP services, and with the exception of pharmacies, the number of outlets has remained mostly constant since its establishment. The NT NSP has also relied entirely on fixed-site distribution. These factors highlight a limitation which has implications for its reach and penetration into the injecting drug use population. These issues will be discussed further in the sub-sections below. It is noted here that expanding the number of outlets by situating them in a range of other relevant organisations (e.g. agencies providing outreach services to the Long Grass People or to remote communities) would arguably address issues of access of NSP services to and for clients. Given the experience of NTAHC and the CDC/Clinic34s, establishing outlets in these other organisations may also have the benefit of adding value to NSP as clients could potentially access a range of other programs and services offered by these agencies.

3.2. NT NSP outputs

The volume of injecting equipment appeared to be consistent with population distribution across the Northern Territory. Consultations with key informants suggested that the NSP is responsive to client needs as indicated by the range of injecting equipment available (including the provision of cotton wool, and wheel filters). Injecting equipment available at NSPs in the Northern Territory appeared to be suitable for the types of drugs that are used (e.g. pill-based pharmaceutical opiates), and are appropriate for the prevention of potential injecting-related harms associated with the use of these drugs. As there are no limits to the numbers of sterile injecting equipment provided to clients, the NT NSP appeared to be sensitive to the geographic issues that are evident within the Territory.

Of note is the decrease in volume of injecting equipment distributed, episodes of information and education provided, and referral episodes during 2010 compared to previous years. Given that a positive trend in these domains was observed from 2007 to 2009, and that proportion of equipment distributed at each location relative to total volume of equipment distributed each year has remained largely constant, the decreases in 2010 may be an anomaly. Trends in these domains for subsequent years from 2010 should therefore be monitored.

Responsiveness of the NSP was also indicated by the range of strategies that are utilised to provide health information and education to clients. Regular campaigns are developed by the primary NSP outlets to raise client awareness of pertinent topic areas, and opportunistic education is provided on an *ad hoc* basis at the primary NSP outlets and CDC/Clinic34s. Education topics identified during consultations appeared to be consistent with what were considered to be important issues for clients.

Of note is the focus on encouraging clients to use wheel filters to minimise the harms associated with pill injecting. However, while the issue was noted as an important concern, the findings from the review suggest that current efforts are not effectively addressing the barriers to the uptake of wheel filters. Additionally, the findings suggest that the provision of information and education is largely dependent on clients initiating the discussion which may limit the potential reach and penetration of health information among NSP attendees. It would be appropriate to consider more proactive approaches to

promote awareness of the benefits of using wheel filters and to address attitudes and perceptions of clients regarding their use.

While it is recognised that services should be responsive to current priorities, there is a risk that other persistent issues may be neglected. The Australian NSP Survey reported that the percentage of respondents in the Northern Territory who reported re-using another person's used needle and syringe in the month prior to the survey has steadily increased from three per cent in 2007 to nine percent in 2009, although it was noted that only three per cent indicated that they had ever re-used another person's used needle and syringe in 2010. It is acknowledged that the proportion of respondents reporting re-use of another person's used needle and syringe is small and lower than national figures. These findings indicate that, while not urgent, maintaining an awareness of blood borne virus transmission and its prevention remains a pertinent issue for injecting drug users in the Northern Territory as in other jurisdictions.

It was noted that interactive strategies for the provision of health information and education were limited to one-on-one approaches. While this approach has the advantage of being highly flexible and can be adapted to individual clients' needs and circumstances, it can be time consuming and repetitive. Of interest is that there are no examples of group-based approaches such as conducting workshops which may be relatively more time efficient – enabling the same type of information to be conveyed to many individuals at the same time while allowing for peer-based group discussions to occur.

Compared to reported episodes of information and education, the number of referral episodes reported was low. However, referral episodes are vulnerable to the types of agencies available to which clients could be referred, and to clients' willingness to raise potentially sensitive issues with staff. The findings indicate that staff attitudes are an important factor that may potentially influence clients' willingness to raise problems for discussion with staff. Openness and interest in clients' concerns are important features which may be conveyed by staff initiating and inviting discussion rather than to rely on clients to raise problems. Physical layout of the service area is also an important factor that influences clients' willingness to raise problems for discussion with staff. While it is acknowledged that the capacity to improve on the physical layout of services is highly constrained, nonetheless it would be useful for

service providers to be mindful of how the physical layout of their service may influence clients. The types of referrals provided however showed that clients have been referred to a range of health and social services and highlight the role of the NSP as a first point of contact between the clients and the health and social service system.

The consultations revealed that inappropriately discarded used injecting equipment in public places is not an issue in the Northern Territory. It provides evidence that the efforts of services to educate clients about appropriate disposal have been effective. As the consultations indicated however, given the distance that clients may have to travel to access disposal bins, efforts to promote clients' awareness of safe storage of used injecting equipment should be maintained.

3.3. Client profile

As with other Australian jurisdictions, the gender profile of clients attending the NT NSP comprises predominantly male injectors. Just over half of total client visits were among those aged 36 years and older, with client visits among those aged 25 years or younger representing a small proportion of client visits. There has been relatively little change in the proportion of client visits from each age group across the past four years.

Of note is that the number of visits by clients of Aboriginal/Torres Strait Islander backgrounds, while representing a small proportion of total client visits, increased from 2007 to 2009, with a subsequent decrease in 2010. The increasing numbers in previous years was consistent with trends in the Northern Territory sample of the Australian NSP Survey. Number of visits by Aboriginal/Torres Strait Islander clients for subsequent years from 2010 should be monitored to determine if the numbers reported for 2010 were an exception to the general increasing trend.

Of concern is that the number of visits by clients from rural or other locations during 2010 has significantly declined compared with other years. When considered alongside a decline in volume of equipment distributed, the findings suggest that equipment distribution in rural and other locations may be compromised. A decline in client visits with an increase in volume of equipment distributed might suggest that rural clients may be picking up more equipment for secondary distribution, but the findings

suggest that this is not the case. The situation should be monitored for subsequent years, and expanding program coverage to rural areas should be considered.

Improving access to NSP services for a number of other sub-populations of injecting drug users were identified as a priority. Primary among these are the "Long Grass People" and residents living within or near the suburb of Nightcliff. As previously indicated, expanding the number of NSP outlets by situating them in relevant agencies providing services to these population groups or within these locations would improve access to NSP services in these areas. Other modalities of service provision should also be considered including mobile/outreach services and/or syringe vending machines.

While it is acknowledged that improving the reach and penetration of the NT NSP through increasing the number of outlets is important, finding ways to tap into current information networks of injecting drug users should also be considered. There was little evidence during the consultations of instances where people accessing NSPs were recruited to be peer educators among people they know who are not accessing NSPs which would facilitate the dissemination of important health information among the broader population of injecting drug users.

3.4. NT NSP coverage

Distance is a significant impediment to achieving adequate geographical coverage, however it was noted that NSP outlets are located at each of the major population centres across the Territory. Consultations with service providers was unable to clarify the extent that people accessing NSPs were from rural and remote areas, and how far they had to travel to access the NSP. It was reported that there were instances of clients accessing large numbers of needles and syringes at their visit to the NSP. However, there may be a number of additional factors to account for this practice including the person's drug use pattern, his or her schedule of visits, and the number of people for whom the person is collecting equipment. Assessing the prevalence of injecting drug use in rural and remote communities was beyond the scope of this project, but to the extent that it may assist in determining the need for NSPs to be established in these areas, such an assessment is warranted. Improved data collection processes may be beneficial in this regard and is discussed below.

Within Darwin, geographic coverage appeared to be poor and mostly focussed within the CBD. Most suburbs are located north of the CBD, with suburbs identified as potentially containing substantial populations of injectors located approximately 8 – 11 km from the CBD.

Coverage across a 24-hour period and throughout the year appeared to be adequate in most population centres, except Darwin. With a complement of the CDC/Clinic34s and the hospital emergency departments in most population centres, there is potentially 24-hour availability of sterile injecting equipment. There are risks, however, with relying on hospital emergency departments as the sole point of access to sterile injecting equipment after business hours, on weekends, and on public holidays. The service provision model is vulnerable to a number of factors including staff attitudes and objections to providing sterile needles and syringes, increases in demand for emergency services, hospital policies, and client perceptions and reluctance to access sterile injecting equipment from these sites. Any of these factors may lead to restricted or no access thereby decreasing the potential coverage of the NT NSP. Coverage (and in particular 24-hour coverage) could be improved through the introduction of syringe vending machines as an additional service modality in these locations and in Darwin. Syringe vending machines are in operation in all but two Australian jurisdictions (Northern Territory and Victoria). An analysis of recent evaluations of trials of syringe vending machines show that they have not detracted from injecting drug users accessing staffed NSPs, but are an effective strategy for improving after-hours access for regular NSP service users, and improving access for sub-populations of injectors who may not normally attend fixed site NSP outlets such as younger injectors and women (Anex, 2010).

As noted above, the hospital emergency department in Darwin does not provide access to sterile injecting equipment. Even if it did, relying on the hospital as a source of injecting equipment when other points of access are closed might have limited impact. It might be difficult for clients to get to the hospital as it is located at the northernmost suburb in Darwin. The introduction of syringe vending machines in Darwin would alleviate some of the issues relating to access. Other strategies that have been previously mentioned, such as expanding the number of outlets and the use of mobile/outreach modalities, should also be considered.

3.5. Linkages and partnerships

Intrasectoral relationships within the Northern Territory NSP, although informal, are coherent and strong across each of the major population centres. It is acknowledged that as in other jurisdictions, secondary NSP outlets have limited capacity to establish and maintain formal linkages and partnerships with other organisations. These are best achieved by the primary NSP outlets. Findings from the consultations suggest that the primary NSP outlets are well linked with a range of other agencies and organisations, and provide a critical link between the NSP sector and these others. Where secondary NSP outlets may not have these links, the strong relationship between secondary outlets and the primary outlets means that they are able to refer their clients on to the primary outlets for further assistance.

Of note is that there are no formal partnerships or protocols between the NSP sector and the police. Given that one of the barriers to accessing services for people who inject drugs is fear of police harassment, establishing formal linkages between both sectors, and the development and communication of clear protocols governing police and NSP operations to police members and injecting drug users would be appropriate. These protocols should be aimed at facilitating access to NSP services by injecting drug users.

3.6. Workforce and professional development

One of the key strengths that was apparent through the consultations was that the NSP is supported by staff who have many years of experience in providing NSP services. This cohort of staff members at NTAHC and the CDC/Clinic34s appeared to be committed to the Program and its objectives, and approach NSP service delivery with an open and nonjudgemental attitude to clients. It was clear from the consultations that their attitudes to NSP service delivery were transmitted to new staff members at these sites who worked with NSP clients in a similarly positive manner.

A formalised and standardised training package such as the package available from the Alcohol and Other Drugs Program has the advantage of ensuring consistent baseline knowledge and understanding across the NSP workforce. However, it was noted that the last formalised workforce training occurred six years ago in 2005. At least four new staff were identified during the consultations as having

commenced delivering NSP services who have not accessed any formal training since they began providing NSP services. Increasing the frequency of formalised training for the workforce is warranted and would be consistent with national NSP practice. For example, in Tasmania face-to-face training is mandated for all staff providing NSP services, and training is delivered by the Department of Health and Human Services.

Within the current context, the primary NSP outlets become the *de facto* training providers in the interim until formalised training workshops become available to staff. In light of this, the role of the primary sites should be acknowledged and supported to ensure an appropriate level of consistency in baseline knowledge and understanding is attained for new staff members from secondary NSP outlets visiting these sites. Additionally, it would be useful to support new staff at secondary outlets (particularly those in distant regional centres) to visit primary NSP sites within a reasonable period after their commencement prior to attending formalised training workshops

As previously discussed, there may be new emerging sub-populations of injecting drug users accessing NSP sites including a younger cohort of injectors. Supporting staff to access training and professional development opportunities to improve understanding and capacity on working with these sub-populations may be warranted.

3.7. Operating costs

The cost for operating NSP in Northern Territory may be divided into costs for provision of sterile injecting equipment, and operating costs including staff salaries and infrastructure (e.g. rent etc) which are mostly borne by the primary NSP sites. The cost for sterile injecting equipment appeared to be relatively low compared to the total cost for operating the NT NSP. The implication of the reliance on secondary NSP outlets for the distribution of sterile injecting equipment is that coverage of the NT NSP is increased with minimal cost.

Average cost per consumable unit is comparable to most other Australian jurisdictions, although there was a slight increase compared with the calculations using the FY2007/08 figures reported in the *Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia*. The

seven per cent increase however is minimal ($0.02) and likely reflects a comparable increase in average volume of equipment distributed during 2007 to 2010.

The majority of the available funding for the NT NSP (approximately 78 per cent) is provided to the three primary NSP sites, which collectively account for more than 80 per cent of the total volume of consumables distributed during 2010. These sites also account for approximately 70 per cent of client visits.

3.8. Data collection and analysis

Current data collection processes are not significantly different from those employed in other jurisdictions, although these processes could be improved. Except for pharmacies, data is collected on the volume of injecting equipment distributed as well as basic client demographics (e.g. age, gender, Aboriginal/Torres Strait Islander background). The data is reported to the Department of Health although only information on volume of injecting equipment distributed is collated for all outlets. Client demographic data from the primary, but not the secondary outlets is collated. The data from secondary outlets has not been collated largely due to difficulties with interpreting the raw data and missing data.

There was general agreement among service providers that the collection of client demographic data can be useful and is a worthwhile exercise. While the consultations did not canvas the types of client demographic information that would be most useful to collect, in undertaking this review, a number of areas suggest themselves. These include (i) age, (ii) gender, (iii) ethnicity, (iv) postcode/town/suburb, (v) drug used, (vi) repeat/new client, (vii) collecting for how many others, and (viii) volume of equipment accessed. Arguably analysing the information in cross-sectional format as a snapshot in time, and over time would be useful in identifying the reach and penetration of the NT NSP, and inform service improvements.

Table 15: Summary of strengths and areas for improvement
SERVICE DELIVERY MODEL

Strengths

- Majority of secondary NSP outlets are located at the CDC/Clinic34s and provide a comparable range of services as the primary NSP outlets.
- Situating NSP in organisations such as NTAHC and the CDC/Clinic34s enables clients to access a range of complementary programs and services offered by these organisations, thereby adding value to the NSP.

Areas for Improvement

- The Program is reliant on relatively small and narrow categories of organisations providing NSP services. The implications are that issues of access for priority population groups, and accessibility of services, are not able to be addressed adequately. Expanding the number of secondary NSP outlets into other relevant organisations would be appropriate.
- Additionally, to address issues of access and accessibility, consideration should be given to other service modalities (e.g. mobile/outreach and/or syringe vending machines).

PROGRAM OUTPUTS

Strengths

- Injecting equipment available at NSP outlets are appropriate to the types of drugs that are injected and appropriate to addressing the potential injection-related harms associated with them. As there are no limits placed on numbers of sterile injecting equipment distributed, the Program is sensitive to the geographic issues present in the Territory.
- A range of strategies are employed to provide clients with health information and education, which are relevant to the issues identified as pertinent for clients.
- Clients are referred to a range of health and social services.
- Inappropriately discarded used injecting equipment in public places is not a significant issue in the Northern Territory – clear evidence that the efforts of services to educate clients about appropriate disposal have been effective.
- Incidence of HIV and HCV infections are below the national average, and rates of sharing of used injecting equipment is lower than the national average.

Areas for Improvement

- Limited uptake of wheel filters by clients was expressed as a concern. More proactive approaches to promote awareness of the benefits of using wheel filters and to address attitudes and perceptions of clients regarding their use should be considered.
- An awareness of blood borne virus transmission and prevention remains an important issue for the Program and should be maintained.
- A reliance on passive awareness raising campaigns, one-on-one and opportunistic education may impact efficiency of providing health information and education. Group approaches should be considered.
- More proactive approaches to initiate discussion with clients rather than to rely on clients to raise problems may convey a more positive and inviting environment and influence clients' willingness to raise potentially sensitive issues with staff.
- Physical layout of services is an important factor that influences clients' willingness to raise problems for discussion with staff. Services should be mindful of the impact of their physical layout.

CLIENT PROFILE

Strengths	Areas for Improvement
• Numbers of visits by clients of Aboriginal/Torres Strait Islander background accessing the Program (while small compared to total number of clients) increased between 2007 and 2009.	• Improving access to NSP to people living in the Long Grass, as well as injectors living within or near the suburb of Nightcliff. • To extend the penetration of information into the injecting drug use population, consider ways to tap into current information networks.

PROGRAM COVERAGE

Strengths	Areas for Improvement
• NSP outlets are located at each major population centre across the Territory. • Program coverage across a 24-hour period and throughout the year appeared to be adequate in most population centres.	• Geographic and temporal coverage in Darwin is limited as the main services are located within the CBD. Improving geographic and temporal coverage is required. • Reliance on hospital emergency departments as the only source of after-hours and weekend access to sterile injecting equipment is vulnerable to a range of factors which may lead to restricted or no access. Alternative modalities to achieve after-hours and weekend access such as syringe vending machines should be considered.

LINKAGES AND PARTNERSHIPS

Strengths	Areas for Improvement
• Strong intrasectoral linkages among NSP outlets. • Primary NSP outlets are well-linked with a range of other agencies and organisations. Given the strong intrasectoral links, secondary outlets are able to refer clients to the primary outlets for further assistance, and clients are able to benefit from the linkages formed by the primary sites.	• Establish formal links with the Northern Territory Police, and develop appropriate protocols aimed at facilitating access to NSP services by injecting drug users who may not be accessing services due to fear of police harassment.

WORKFORCE AND DEVELOPMENT

Strengths

- Stable workforce comprising of staff who have many years of experience and who are committed to providing NSP services. On-the-job training provided by these staff members appear to be adequate in transmitting these attitudes to new staff members.
- Staff at primary NSP sites possess and/or are required and supported to obtain appropriate formal qualifications which provide competencies in working in community services and/or with alcohol and drug related issues.
- Primary outlets provide opportunities for new secondary NSP staff members to visit and learn about how the Program is delivered which is considered useful.

Areas for Improvement

- The last formalised workforce training occurred six years ago. Increasing the frequency of formalised training for the workforce is warranted. This would include understanding rationale for NSP services, knowledge of types of drugs that are commonly used and the implications for service delivery, and importantly, potential issues faced by clients and ways to address client needs.
- The primary NSP sites set the benchmark for NSP service provision. To ensure consistent baseline knowledge and understanding across the NSP workforce, a formalised method for site visits should be considered.
- Access to site visits by secondary NSP staff may be limited due to distance for some outlets. Supporting staff from distant regional centres to visit primary NSP site as part of their induction to providing NSP services should be considered.

PROGRAM COSTS

Strengths

- Per unit cost for consumables appeared to be comparable to most other Australian jurisdictions.
- Reliance on secondary NSP outlets to supplement the primary outlets means that Program coverage is increased at minimal cost.

DATA COLLECTION AND ANALYSIS

Strengths

- Data is collected on volume of equipment distributed which allows for ongoing monitoring of trends.
- Data is collected by NSP outlets on client demographics.

Areas for Improvement

- Client demographic data from all outlets is not collated and reported to services. The main drawback is that the capacity to monitor Program reach and penetration is limited. Standardised data collection forms and reporting mechanisms are in place, however improvements in data collection and reporting from secondary NSP outlets is warranted.

4. Conclusion and recommendations

The objectives of the present review were to determine the effectiveness and efficiency of the NT NSP in meeting its objectives. Specifically the evaluation sought to identify (i) the extent to which the objectives of the NT NSP have been achieved, and (ii) whether current NSP services represent the most appropriate, effective and efficient means for achieving these objectives.

While there is no formal policy document that sets out the aims and objectives of the NSP in the Northern Territory, consultations with key informants and references to the *National Strategic NSP Framework 2010 – 2014*, suggest the following working definition of the NT NSP aims and objectives may be an appropriate starting point:

Aim

To protect the health, social, and economic wellbeing of the community with a focus on the prevention of blood borne virus transmission and other injection-related harm among people who inject drugs and the broader community.

Objectives

- To provide sterile injecting equipment and safe disposal facilities for used injecting equipment to people who inject drugs.
- To provide information and education to people who inject drugs on drug-related issues and other health-related matters.
- To refer clients to other health and social services as appropriate to promote physical and mental health and wellbeing.

The findings indicate that outputs of the NT NSP are consistent with these objectives. Specifically, the NT NSP continues to supply equipment that are suitable to the types of drugs that are injected, and have the potential to prevent injecting-related harm associated with these drugs. The policies surrounding the supply of sterile injecting equipment are also sensitive to the geographic issues that are evident within the Northern Territory thereby minimising the potential negative impact from large geographical distances. Whether the decline in volume of equipment distributed in 2010 represents an anomaly or is indicative of a downward trend should be closely monitored.

The NT NSP continues to provide clients with access to health information and education through a range of strategies including accessible written material in the form of pamphlets and brochures, coordinated education and awareness raising campaigns, and one-on-one opportunistic education episodes. These strategies target a number of pertinent drug-related issues that are experienced by clients such as pill filtering and safe disposal of used injecting equipment. Uptake of wheel filters, which would be a more effective means of filtering a pill-based drug mix and thereby prevent injection-related injuries, is low. More proactive approaches to promote awareness of the benefits of using wheel filters and to address attitudes and perceptions of clients regarding their use should be considered.

While it is important to address emerging issues, care needs to be taken that persistent ongoing issues such as blood borne virus transmission and prevention are not neglected. There is no evidence to suggest that this is the case, but services should be mindful that prevention of blood borne virus transmission remains important.

The NT NSP continues to provide information and referrals to a range of health and social services to clients including mental health services, general practitioners, and other alcohol and drug services such as detoxification and pharmacotherapy services. Compared with reported episodes of information and education provision, the number of referral episodes reported is low. However, referral episodes are vulnerable to the types of agencies available to which clients could be referred, and to clients' willingness to raise potentially sensitive issues with staff. The range of referrals provided to clients indicated that the NT NSP is fulfilling its role as a first point of contact between clients and the health and social service system. More proactive approaches to initiate discussion with clients rather than to rely on clients to raise problems would convey a more positive and inviting environment and influence clients' willingness to raise potentially sensitive issues with staff. A review of the physical layout of services to address any perceived barriers that this may impose should also be considered.

Inappropriately discarded used injecting equipment is not a significant issue in the Northern Territory. Efforts of services to educate clients about appropriate disposal of used injecting equipment therefore appear to be effective.

Finally, based on the data collected through the primary NSP outlets, there is a general trend for an increase in numbers of client visits by people of Aboriginal/Torres Strait Islander backgrounds, although they constituted a small proportion of total client visits. Number of visits by clients of Aboriginal/Torres Strait Islander backgrounds during 2010 was an exception to this general trend and should be monitored to determine if it is indicative of an ongoing downward trend. Similarly, access by injectors from rural and other locations to NSPs in Darwin and Palmerston should be investigated

A number of strengths characterise the NT NSP. These include cohesive and supportive services that are well linked with each other, and an experienced workforce that is committed to its objectives. The primary NSP outlets play a key role in providing a critical link between the NSP sector with a range of other agencies and organisations. The strong relationships between the secondary outlets and the primary outlets suggest that secondary outlets which may have limited capacity to refer clients onto other health and social services, may potentially and reportedly do refer their clients on to the primary sites for further assistance.

While the current service delivery model of the NT NSP appears to be appropriate and effective in delivering its objectives, further improvements are required to respond to persistent and emerging issues and challenges. Specifically, while coverage is adequate in most population centres in the Northern Territory, there is a need to improve access to services across geographic locations, and across a 24-hour period throughout the year. This issue is particularly significant for Darwin where arguably the majority of injecting drug users are located. There is also a need to improve access to services for injecting drug users generally as well as for specific sub-groups such as people who are homeless and living in the "Long Grass". To respond to these issues, increasing the number of NSP outlets is warranted. This could be achieved in a number of ways including establishment of outlets within relevant organisations that are providing services to these populations, introducing mobile/outreach services, and introducing syringe vending machines. Assessing the prevalence of injecting drug use in rural and remote communities may be warranted in the future to the extent that it may assist in determining the need for NSPs to be established in these areas.

Other issues to be addressed include the lack of availability of regular and timely formal training programs for staff. The development of appropriate monitoring processes such as improved reporting mechanisms would be helpful to enable continued planning and improvement of the NT NSP. Given that fear of police harassment is an impediment to accessing services for injecting drug users, it is critical for the Northern Territory Police and NSP to work collaboratively to develop protocols aimed at facilitating access to NSP services by injecting drug users.

The review identified a number of issues which require further investigation. Understanding the prevalence of steroid injecting, and the knowledge and practices of steroid injectors in regard to preventing associated harms (such as blood borne viruses) would be useful to determine the extent to which it is a potential problem in the Northern Territory. Given that pharmaceutical opiates are the main drugs injected and that uptake of wheel filters is low, injecting drug users in the Northern Territory are potentially at risk of a range of injection-related injuries such as abscesses and skin ulcers which if untreated may lead to further infections and possible amputation. An assessment of the prevalence of injection-related injuries and harms may be warranted. Finally, a number of issues were raised in relation to the opiate pharmacotherapy program including its accessibility and the potential negative impact of the policies surrounding its operation on patients. A review of the operation of the opiate pharmacotherapy program and patient outcomes should be considered.

Based on an analysis of the findings from the review a number of recommendations were identified. These recommendations are reproduced below – beginning with recommendations for the Department of Health, followed by recommendations pertaining to NSP services. It is recommended that:

1. The **Department of Health** maintain the current level of funding for NSP, and undertake regular reviews on the need for increased funding to address emerging issues and challenges.

2. The **Department of Health** improve the reach and penetration of the NT NSP (particularly in Darwin) through expanding the number of outlets including the establishment of additional secondary outlets situated in relevant agencies that provide services to priority groups (including the Long Grass People, and injectors living within or around Nightcliff).

3. The **Department of Health** improve coverage of the NT NSP through the expansion of service delivery modalities including the introduction of syringe vending machines to improve after-hours access to sterile injecting equipment.

4. The **Department of Health** continue to monitor the trends in NT NSP outputs and client visits.

5. The **Department of Health** provide financial assistance to secondary NSP outlets in distant regional centres to enable induction of new staff through visits to primary NSP sites.

6. The **Department of Health** review current arrangements in relation to workforce development and training to ensure that formalised training is provided to all staff on a regular basis with appropriate frequency.

7. The **Department of Health** liaise with NSP services to ensure that quality of data collected and reported on client visits is of a standard that would enable the reach and penetration of the NT NSP to be assessed over time.

8. The **Department of Health** facilitate the establishment of formal linkages between the NSP sector and Northern Territory Police with the aim of improving access to NSP services by injecting drug users.

9. The **Department of Health** provide funding to enable an investigation into the prevalence of steroid injecting within the Northern Territory, and its associated harms.

10. The **Department of Health** provide funding for an assessment of the prevalence of injection-related injuries and harms associated with pharmaceutical opiates.

11. The **Department of Health** undertake a review of the operation of the opiate pharmacotherapy program and patient outcomes.

12. **Primary NSP services** review and formalise the program for site visits by new NSP staff across the Territory so as to contribute to consistent knowledge and understanding of NSP-related matters across the NSP workforce.

13. **NSP services** continue to maintain and promote awareness among clients of safe storage and disposal of injecting equipment; safer injecting practices (including the use of wheel filters); and blood borne virus transmission and prevention.

14. **NSP services** be more proactive in promoting client awareness of the benefits of using wheel filters and address attitudes and perceptions of clients regarding their use.

15. **NSP services** investigate the use of group approaches to complement existing strategies for information provision and education for clients, and consider ways to utilise peer information networks to improve the reach and penetration of health promotion messages to injecting drug users.

16. **NSP services** be mindful of the impact of physical layout on clients' ability and willingness to approach staff to discuss problems, and where possible to minimise the negative impact.

17. **NSP services** take a proactive approach in providing information, education and referrals to clients.

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Appendix 1: NSP Client Consultations Interview Schedule

Client demographics

☐ Male ☐ Female

Can you tell me your age please?

☐ 18 – 20 ☐ 36 – 40
☐ 21 – 25 ☐ 41 – 45
☐ 26 – 30 ☐ 46 – 50
☐ 31 – 35 ☐ 51 - older

Are you of Aboriginal or Torres Strait Islander background?

☐ Yes ☐ No

*If no, how would you describe your ethnic background?*_____

Which town or suburb do you live in?_____

How long have you been injecting for?_____

What drug do you commonly inject?_____

In the last week which drug or drugs have you injected?_____

Program Objectives and Outcomes/Impact

What do you think are the reasons we have needle exchange?

Would you strongly agree, agree, disagree, or strongly disagree that needle exchanges or NSPs are achieving what they were set up to do?

Strongly Agree Agree Disagree Strongly Disagree Not Sure

Service Delivery

How often do you use the following services when you visit the needle exchange?

Eg. When you visit the needle exchange, how often do you pick up injecting equipment? Is it daily, every few days, weekly, monthly or never?

Eg. When you visit the needle exchange, how often do you dispose injecting equipment? Is it daily, every few days, weekly, monthly, or never?

When you visit the needle exchange, how often do you…..	Daily	Every few days	Weekly	Monthly	Never
Pick up injecting equipment					
Dispose injecting equipment					
Get information about HIV					
Get information about hep C					
Get information about using safely					
Get information about methadone/bupe					
Get information about where to go for drug treatment					
Get information about other health services you want to access					
Get help/referral to get into a methadone/bupe program					
Get help/referral to get into drug treatment					
Get help/referral to get into other health services					
Go there for general support / chat					

Since December last year, have you *ever* received the following from an NSP? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months

Is there anything else that you visit needle exchanges for that I haven't mentioned?

Are there services that you would like to be able to access at the needle exchange/NSPs that are not currently available?

On average how much time do you spend at the NSP on each visit?
□ Less than 1 minute (in and out usually)
□ 1 – 5 minutes (sometimes stay for a quick chat)
□ 5 – 10 minutes (sometimes stay for a chat or get information)
□ More than 10 minutes (sometimes hang around to talk/get information/referral)

When you pick up injecting equipment at the exchange/NSP, is that also for other people?

□ Yes □ No

If yes, how many others were you picking up for? ……..

Which town or suburb do they live in? ……

Do you usually charge them for the equipment you picked up or do you give them out for free? □ Charge □ Free

Have you ever talked to a needle exchange/NSP worker about a problem you might have?

□ Yes □ No

If yes, who started the conversation? □ Client □ Worker

What things make it easier for you to talk to a needle exchange/NSP worker about a problem you might have? *(tick all that apply)*

Prompt: What else …?

□ Staff show interest in how I am
□ Staff are friendly
□ Having space to sit or be comfortable
□ Having a private space to discuss problem
□ Other (please specify)……..

What factors have discouraged you in the past or would discourage you to talk to an NSP worker about a problem you might have? *(tick all that apply)*

Prompt: What else …?

□ Staff are too busy
□ Exchange is too crowded
□ Staff are not approachable
□ Staff were not interested in hearing about my problem in the past
□ Approached someone in the past and had a bad experience
□ Concerned about privacy / confidentiality
□ Other (please specify)……..

Has the NSP you visit ever:

Provided information to you about another service or agency that you wanted to visit?
□ Yes □ No

Helped you to get into another service or agency? □ Yes □ No

If yes, which services or agencies did they help you get into?

If yes, overall how satisfied were you in the way that the NSP helped you?

□ Very satisfied□ Satisfied □ Quite satisfied □ Not satisfied

Access

Where do you usually go to get your sterile injecting equipment?

How much time does it take from your home to get to the nearest place where you can pick up sterile injecting equipment?
□ 1 – 10 minutes
□ 10 – 30 minutes
□ 30 – 40 minutes
□ More than 60 minutes

What about from the place where you get your drugs?
□ 1 – 10 minutes
□ 10 – 30 minutes
□ 30 – 40 minutes
□ More than 60 minutes

What about from the place where you inject?
□ 1 – 10 minutes
□ 10 – 30 minutes
□ 30 – 40 minutes
□ More than 60 minutes

Which of these statements would you most agree with?
□ It is very easy for me to get to an outlet no matter where I am
□ It is a bit difficult for me to get to an outlet no matter where I am
□ It is very difficult for me to get to an outlet no matter where I am

How many people do you know who inject but don't pick up their equipment from NSPs?
_____

Where do you think they get their equipment from?

What are some of the reasons they don't pick up equipment from NSPs?

Prompt: What other reasons might they have?

What do you think can be done to encourage people who don't use NSP to visit them? *Prompt:* What else ..?

In the last four weeks, how many times have you needed sterile injecting equipment but have not been able to get it?
□ None – always been able to access sterile injecting equipment
□ 1 – 2 times
□ 3 – 5 times
□ 6 – 10 times
□ 10- 15 times
□ 15 – 20 times
□ More than 20 times (at least once a day on average)
□ Other (please specify)……..

Can you describe the situation when you have not been able to get sterile injecting equipment? What was the reason?

When you have not been able to get sterile injecting equipment, what did you do?

Consumables

What types of equipment do you usually pick up from the NSP? *(tick all that apply and probe for items that are not mentioned)*
□ Needle & Syringe (1ml)
□ Needle & Syringe (other) ……..
□ Needles (single) ……..
□ Syringes (single)…….

□ Sterile water ampoule
□ Swabs
□ Wheel Filter
□ Cotton
□ Disposal bins/container (what size?) ……..
□ Other (please specify)……..

What else do you think should be provided? *(tick all that apply and probe for items that are not mentioned)*
□ Needle & Syringe (1ml)
□ Needle & Syringe (other) ……..
□ Needles (single) ……..
□ Syringes (single)……
□ Sterile water ampoule
□ Swabs
□ Wheel Filter
□ Cotton
□ Tourniquet
□ Butterfly
□ Disposal bins/container (size) ……..
□ Other (please specify)……..

Service Delivery Model

Have you ever accessed NSPs at the Clinic 34?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from this type of NSP? *(Circle option in parenthesis)*

□ Information about a health-related topic (Was that verbally/brochure or both?)

□ Information about another health service or agency

□ Referral to a health service or agency

□ None in last 6 months

□ Did not visit this type of NSP in last 6 months

Have you ever accessed NSPs at pharmacies/chemist?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from an NSP at a pharmacist/chemist? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months
- □ Did not visit this type of NSP in last 6 months

Have you ever accessed NSPs at the Northern Territory AIDS and Hepatitis Council on Wood Street in Darwin?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from this NSP? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months
- □ Did not visit this NSP in last 6 months

Have you ever accessed NSPs at the Northern Territory AIDS and Hepatitis Council on Railway Terrace in Alice Springs?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from this NSP? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months
- □ Did not visit this NSP in last 6 months

Have you ever accessed NSPs at the Northern Territory AIDS and Hepatitis Council in Palmerston?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from this NSP? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months
- □ Did not visit this NSP in last 6 months

Have you ever accessed NSPs at hospital emergency departments?

If so, what do you like about this kind of outlet?

What don't you like about it?

Since December last year, have you *ever* received the following from this type of NSP? *(Circle option in parenthesis)*

- □ Information about a health-related topic (Was that verbally/brochure or both?)
- □ Information about another health service or agency
- □ Referral to a health service or agency
- □ None in last 6 months
- □ Did not visit this type of NSP in last 6 months

Other Comments

Are there any other issues you would like to tell us or do you have any other comments?

Appendix 2: Service Provider Interview Schedule

Name: …….. Position: ……

Please briefly describe your role and your involvement with NSP services.

Program Objectives and Outcomes/Impact

How would you describe the objectives of your NSP service?

In light of this, to what extent would you agree that your service has achieved its objectives?

Strongly Agree Moderately Agree Agree Disagree Not Sure

Why do you say that?

What would you consider are the priority populations for your service?

What do you consider are the priority issues for your service?

What do you consider are the priority issues for NSPs generally?

Approximately how many needles and syringes are distributed through your service each month?

Can you describe the services that you provide to clients?
- ☐ Injecting equipment
- ☐ Disposal facilities
- ☐ Brochures/pamphlets
- ☐ Referrals ……

What kinds of education/information do you provide to clients? How often? What is the process?

What kinds of services do you refer clients to? How often? What is the process?

Client Needs

How many clients access your service each month? What are their demographics?

What differences – if any – are there between people accessing NSPs compared to those who do not?

What types of concerns do clients potentially have?

Are there client needs that are not being met? And why do you think this might be happening?

What processes are currently in place to address this gap?

What types of drugs are currently being used? And what implications does this have on NSP service delivery?

What is your perspective on the hours of operation of services vis a vis client needs? And your perspective on achieving 24-hour access to sterile injecting equipment?

Service Delivery Model

Who is responsible for providing NSP services? Approximately what proportion of staff time would be allocated to NSP service provision?

What factors facilitate service delivery?

What are some challenges you face?

Who is responsible for disposal of used injecting equipment?

Overall, how would you characterise the strengths of your service?

How would you characterise the weaknesses of your service?

Are there particular ways that your service could be improved?

Are there strengths and limitations that are specific to particular types of outlets (such as primary, secondary, pharmacy-based)?

How could the model be improved?

Consumables

What types of equipment are currently being provided?
□ Needle & Syringe (1ml)
□ Needle & Syringe (other) ……..
□ Needles (single) ……..
□ Syringes (single)…….
□ Sterile water ampoule
□ Plastic spoon
□ Wheel Filter
□ Other (please specify)……..

Do you charge clients for any of these consumables? If so, which ones and how much?

What else do you think should be provided?
□ Needle & Syringe (1ml)
□ Needle & Syringe (other) ……..
□ Needles (single) ……..
□ Syringes (single)…….
□ Sterile water ampoule
□ Plastic spoon
□ Wheel Filter
□ Other (please specify)……..

Linkages and Partnerships

Does your NSP have formal links with other community services eg. police, local government, pharmacies, drug treatment agencies/services, other health and welfare agencies/services? How would you characterise these linkages?

What would you consider are key services that NSPs ought to link with? Are you aware of linkages that other NSPs have with these services? How would you characterise these linkages?

What linkages are there between NSP services with each other? How would you characterise these linkages?

In your view, is there a role for the funded agencies to support unfunded agencies? Why or why not?

Training and Workforce Development

In your view, is there a minimum knowledge-base required to work in an NSP? If yes, please specify.

What training and professional development opportunities do staff currently receive?

What else should be made available?

Data Collection and Reporting

What are the data collection and reporting requirements?

What kinds of data are collected?
☐ Client Demographics (sex/age)
☐ Equipment distributed
☐ Drug use
☐ Education episodes
☐ Referral episodes
☐ Other (please specify)……

Are the data collected adequate? If not, what else should be collected?

How do use the data you collect?

To what extent would you agree or disagree with the following statement?

All NSPs (primary and secondary) should collect data on client demographics (age/gender)

Strongly Agree Moderately Agree Agree Disagree Not Sure

Why do you say that?

Industry / Best Practice Standards

What best practice standards (if any) currently apply nationally to NSPs?

What standards (if any) ought to be applied?

Costs

What would you estimate to be the overall cost of running your service? How are these apportioned? (e.g. staffing, rental, consumables)

Foreseeable Developments

What are the priorities for future plans and strategies?

Are there new and emerging challenges that need to be focussed on?

Are current models and levels of service delivery able to meet these challenges? If not, why not? What is required?

How would you describe the sustainability of the program in its current form?

Thinking about what we have discussed, what changes, if any, have there been between 2007 and now that might have influenced or affected the Program**?**

Other Comments

Are there any other issues you would like to bring to our attention in evaluating the NSP? Or do you have any other comments?

Appendix 3: Other Key Informant Interview Schedule

Name: …….. Position: ……

Please briefly describe your role and your involvement with NSP services, if any.

Program Objectives and Outcomes/Impact

How would you describe the objectives of the Program?

In light of this, to what extent would you agree that the Program has achieved its objectives?.

Strongly Agree Moderately Agree Agree Disagree Not Sure

Why do you say that?

What do you consider are the priority populations for the Program?

What do you consider are the priority issues that are pertinent to NSPs?

Client Needs

What do you consider are pertinent issues for injecting drug users in the Northern Territory?

How well do you think these issues are being addressed?

What else could be done to address these issues?

What contribution can NSPs make to addressing these issues?

Linkages and Partnerships

Are you aware of any formal linkages that NSPs have with other community services eg. police, local government, pharmacies, drug treatment agencies/services, other health and welfare agencies/services? How would you characterise these linkages?

What would you consider are key services that NSPs ought to link with? Are you aware of linkages that NSPs have with these services? How would you characterise these linkages?

Training and Workforce Development

In your view, is there a minimum knowledge-base required to work in an NSP? If yes, please specify.

What training and professional development opportunities do staff receive or should be offered?

Industry / Best Practice Standards

What standards (if any) currently apply nationally to NSPs?

What standards (if any) ought to be applied?

Foreseeable Developments

Are there new and emerging challenges in relation to drug use that need to be focussed on?

How well do you think these issues are being addressed?

What else could be done to address these issues?

What contribution can NSPs make to addressing these issues?

Other Comments

Are there any other issues you would like to bring to our attention in evaluating the NSP? Or do you have any other comments?

Review of the Northern Territory Sobering Up Shelter Services

NORTHERN TERRITORY DEPARTMENT OF HEALTH
ALCOHOL AND OTHER DRUGS PROGRAM

July 2013

TABLE OF CONTENTS:

ACRONYMS

AADANT	Association of Alcohol and Drug Agencies NT
AODP	Alcohol and Other Drugs Program
ADSCA	Alcohol and Drug Services Central Australia
BRADAAG	Barkly Region Alcohol Drug Abuse Advisory Group
CP	Community Patrols
CRE	Council of Respected Elders
DASA	Drug and Alcohol Services Association Alice Springs
DoH	Department of Health
EASC	East Arnhem Shire Council
GMF	Grants Management Framework
GMS	Grants Management System
JC	Julalikari Council
KCI	Kalano Community Incorporated
MA	Mission Australia
MOU	Memorandum of Understanding
NAODRS	Nhulunbuy Alcohol & Other Drugs Rehabilitation Service
NT	Northern Territory
NTG	Northern Territory Government
NTP	Northern Territory Police
SAAS	Service Agreement Administration System
SUS	Sobering Up Shelter
TES	Top End Services
TCI	Tangentyere Council Incorporation

EXECUTIVE SUMMARY

The objective of this review is to evaluate the nature of the services provided by Sobering Up Shelters (SUS) in the Northern Territory and consider how they may be enhanced and strengthened.

The Review is seeking to determine and assess:

1. the evidence base for Sobering Up Shelter operations nationally;

2. the capacity of a SUS to meet DoH *Guidelines for the Establishment and Operation of a SUS*, including provision of brief interventions, referral pathways, staff training and performance reports;

3. the capacity of a SUS to identify a person at risk of harm to him/herself and/or a risk to others and the harm minimisation strategies utilised as a result of any such identification;

4. the current working relationships between SUS, key stakeholders and other AOD service providers, including access to the shelters and referrals from the shelter, particularly for frequent users of the SUS service; and

5. responsiveness to local needs and conditions including current protocols and/or policies for admission to and discharge from a SUS.

The review was conducted using a combination of quantitative and qualitative methods.

Performance data from each of the shelters was analysed to identify trends in admission, capacity for enhancing service delivery and areas requiring intensive support and assistance from the Department of Health.

Interviews were held with service providers and key stakeholders who work with the shelter to identify referral practices and processes and to seek input into appropriate service improvements through issue identification and solution options.

Interventions and actions that contributed to positive client outcomes were discussed and the application of such practices across all shelter services is discussed further in this report.

The review identified that approximately 18 000 people per annum are admitted to SUS services across the NT. Whilst the primary purpose is to provide a safe place for intoxicated and vulnerable people to sober up, there are also expectations that client outcomes will be improved through the delivery of brief interventions, referrals to treatment service upon discharge and adequate follow up procedures in place.

The Review identified significant issues with a number of processes and practices including the delivery of brief interventions, referral processes and follow-up and limited collaboration among regional treatment service providers. If the intent of SUS services is to support clients to undertake behavioural change linked to their alcohol misuse, there needs to be a far greater emphasis on referrals to treatment services and more assertive/appropriate follow-up procedures in place.

This is particularly important for those frequently admitted into the shelter. There is no formal mechanism that would require a person from a Sobering up Shelter to be mandated to treatment, even though this may be of benefit to their long term health. However, should such a mechanism be introduced, it could be expected that clients may avoid the Police and night patrols, thereby increasing their risk of harm. This would result in a decrease in admissions to sobering up shelters and an increase in adverse client outcomes.

Each of the SUS services identified referrals as a key issue – with one service stating that the majority of clients refuse or fail to attend. Clients can legitimately make this choice, however if SUS services are being evaluated on their ability to refer clients to appropriate treatment services, they will never achieve a satisfactory outcome as factors beyond their control are limiting their effectiveness. Without appropriate referral and follow-up, client outcomes will remain limited.

Underpinning all of this is the commitment of the client to undertake behavioural change to address their substance misuse. Without this commitment, any effort by the SUS services to intervene and/or to provide post-discharge treatment will have limited lasting impact.

Each of the SUS service providers and a number of stakeholders suggested that a more client focussed service could be delivered if the service operated 24 hours a day, 7 days per week. Data from each of the services showed a clear distinction between peak demand times and periods of low occupancy. On that basis, it is recommended that in consultation with AODP, community patrols and NT Police, operating hours of each SUS service be amended to reflect their respective peak demand times. It is further recommended that processes and practices to enhance referrals and follow-up activities should be addressed with each service as part of a review of the SUS Guidelines.

The Review also identified inadequate monitoring, analysis and follow up of performance reporting data by AODP. Reports provided by service providers regularly failed to achieve tasks identified in the SUS guidelines, particularly in relation to training and development of staff, the delivery of brief interventions and follow up processes related to referrals. There is no evidence that any remedial action was taken to address such issues. It is recommended that the data collected and reported upon by each SUS be reviewed to ensure appropriateness and consistency across each service and to ensure it is clearly linked to performance reporting requirements.

Performance reporting issues may be overcome in part by the introduction of an electronic reporting system; however this will not assist in the analysis of data to ensure the services are operating in accordance with the guidelines and Service Level Agreements. Any actions to improve the operations of funded services require that decisions actions and strategies that must be fully supported by the Department of Health.

SUS services operating in other jurisdictions operate on a 24 hours per day 7 days basis. Bed capacity for the centres ranges between 4 and 12 beds and this enables them to focus on individual treatment and care plans. Operating guidelines provided by other jurisdictions contain similar elements and principles to those used in the NT and provide a broad, client focussed approach to delivering services whether it be as a lead-in to treatment for substance misuse or as a place of safety or shelter. Organisations in other jurisdictions also reported difficulties in coordinating referrals, delivery of brief interventions and follow-up.

The challenge in SUS services is that clients are there voluntarily and they can leave at any time without any real consequences. Whilst each SUS service identified clients absconding whilst intoxicated and indicated that Police are notified, there is no data to support any follow up action. It is unknown how many of these clients were then picked up and transported to Police Protective Custody, to their home, or back to the SUS.

A complete review of the SUS operating guidelines, along with a reaffirmation of the purpose and intent of sobering up shelters is a priority. This will ensure that guidelines are realistic and achievable, funded services and Government are working together to improve client outcomes, and that performance reporting is not simply a collection of statistics that are submitted without any scrutiny, analysis or follow-up by AODP.

RECOMMENDATIONS

During the review, a number of issues were raised by service providers and stakeholders that require appropriate and timely resolution. In addition, analysis of data provided for performance reporting purposes has identified a number of areas for improvement in order to enhance the delivery of services and client outcomes for each SUS.

Broadly, the recommendations are based around the following five categories:

- Resources, infrastructure and facilities;
- Reporting;
- Procedural guidelines;
- Training and development; and
- Communication and inter-sectoral relationships.

Resources, infrastructure and facilities

Recommendation one
Each SUS service works with AODP to realign operating times and staff numbers (days and hours) for the efficient provision of services during high demand/peak periods including major community events.

Recommendation two
Undertake formal site assessment of the SUS facilities in Darwin and Alice Springs and identify any capital or minor new works required to bring them to a consistent and acceptable standard. These sites are a priority as Nhulunbuy, Katherine and Tennant Creek SUS are newly constructed and built to specific contemporary design standards.

Procedural guidelines

Recommendation three
That the *'Guidelines for the establishment and operation of a Sobering Up Shelter Service under the NT Sobering Up Shelter Program 2nd Edition'* be reviewed and where necessary, updated.

Specific areas for attention raised during the review include:

- Incorporating recommendations (if any) from NT Coronial Court hearings
- qualifications of staff
- referral procedures – (including self referrals or walk-ins)
- record keeping and performance reporting
- duration of stay
- frequent admissions by individual clients
- refusing entry to clients
- admission practices for self-referral/walk-in clients

Recommendation four
Undertake a trial program using hand held breath-testing devices in Sobering Up Shelters to determine whether their use is an effective tool in measuring intoxication and assisting in determining appropriate client care options and safe discharge practices.

Recommendation five
Investigate the strategies to reduce the number of short length of stay admissions (especially less than one hour) and implement strategies to encourage clients to stay in the SUS long enough to sober up and have a meal.

Reporting

Recommendation six
Undertake a review of the data collected and reported upon by each SUS to ensure consistency across each service and to ensure it is clearly linked to performance reporting requirements and improved client outcomes.

Training and development

Recommendation seven
Refresher training must be provided to all existing staff and a process to train all new staff in the use and value of computerised record systems within a set period of their commencement.

Recommendation eight
Certificate level training for care workers should remain a requirement and it is recommended that five core competencies be addressed within 6-9 months of commencing employment.

These are:

- Work with clients who are intoxicated;
- Work effectively with culturally diverse clients and co-workers;
- Use targeted communication skills to build relationships;
- Provide brief intervention; and
- Work effectively in the Alcohol and Other Drug sector.

Communication and inter-sectoral relationships

Recommendation nine
Each SUS engage with treatment services and housing service providers regarding local communication and opportunities for collaboration within their region to enhance referral processes and practices. It is proposed that initial regional workshops be coordinated by AODP to ensure an approach that is aligned to Service Level Agreements and consistent with the referral process contained with the current guidelines.

Recommendation ten
Plan client discharge times from the SUS to align with an outreach worker to the local treatment agency to assist client participation in referrals in order to improve client outcomes.

Recommendation eleven
In collaboration with Mission Australia, undertake a trial a program to utilise the Katherine SUS premises as an outreach service during the day.

Recommendation twelve
AODP develop an annual plan for quarterly face to face meetings with all SUS services, supported by regular email and telephone communication. Whilst it is recognised that the current linkages with AODP and other SUS services are well regarded and of significant use, formal contact will facilitate the timely identification and resolution of issues and is likely to enhance the delivery of services and improve client outcomes.

Recommendation thirteen
In collaboration with the Australian Government, review referral and transportation processes with community patrols to encourage use of the SUS as the preferred first point of call rather than transporting intoxicated people to home and to investigate patterns of patrol transfers and outcomes related to anti-social behaviour.

Recommendation fourteen
For high risk clients with multiple SUS admissions within a year, investigate options for entry into treatment services including referral for assessment for mandatory treatment orders.

INTRODUCTION

The Northern Territory (NT) Sobering-up Shelter (SUS) Program was established in January 1983 and the first shelter was opened in Darwin in August 1983, operated by the Salvation Army. Shelters, managed by non-government organisations, have now been established in each of the five regional centres, Darwin, Katherine, Tennant Creek, Alice Springs and Nhulunbuy.

The Department of Health, Alcohol and Other Drugs Program (AODP) funds Mission Australia (MA), East Arnhem Shire Council (EASC), Barkly Region Alcohol Drug Abuse Advisory Group (BRADAAG) and Drug and Alcohol Services Alice Springs (DASA) to deliver sobering up shelter programs/services in five regions of the NT.

SUS services are one component of a broad-based service system continuum to address alcohol misuse issues by the NTG.

The issue of substance abuse, particularly alcohol with the devastating effect this has on entire communities, remains a key priority in the NT. Government has provided the framework to tackle these issues and supports initiatives to increase the alcohol and other drug sector's capacity to respond through care and protection, prevention, treatment and rehabilitation services.

Tackling substance abuse and the damage it causes is a key priority. This will require government agencies, the non-government sector and the community to establish coordinated responses to address the associated social, health and well-being problems resulting from substance abuse.

In 1999, AODP developed a set of guidelines for the management of sobering up shelters. The 'Guidelines for the Establishment and Operation of a Sobering-up Shelter under the Northern Territory Sobering-up Shelter Program' has been used to negotiate service agreements with the non-government organisations managing the shelters in the five urban centres.

NT-wide operating guidelines were up-dated in 2009 to reflect changing circumstances with regard to the health and welfare of shelter clients and to the current policies and standards expected from organisations managing the shelters.

The Executive Director Strategy and Reform commissioned the review given expected changes to the alcohol and other drugs service system, AODP's desire for regular program evaluation and to gain feedback from key stakeholders about service operations.

The review aims to:

- Provide a brief description of the services provided (including location, times, personnel, interventions etc)

- Assess the effectiveness of the service, including assessing:
    - whether the services delivered is meeting the outcomes specified in the Service Plan by reviewing whether the service outputs are being met and performance measures are being achieved;
    - if the service is meeting national standards; and
    - whether the location(s) of the service best meet the needs of the target client group.

- Determine the appropriateness of the service, including: determining if the service types contribute to meeting the alcohol and other drug service needs within the particular region.

During the review process, AODP worked with the managers and staff of the five shelters to identify strengths, issues, challenges and options for resolution. Consultation with other stakeholders was also undertaken.

A complete list of stakeholders consulted during the review process is in Appendix 1: Consultation List

METHODOLOGY/CONSULTATION

The methods used to conduct the review and prepare the Report include:

- a desktop review of the relevant documents including: Performance Reports; the Agreement between Department of Health and the Service Plan; correspondence between the DoH and the service providers; relevant policies and guidelines provided by service providers;

- service data for the 2012 calendar year, and where appropriate, previous year's data

- interviews with relevant stakeholders (see Appendix 1: Consultation List).

- documenting the findings and producing a report;

- discussion of the report and recommendations with the Reference Group and DoH Executive members.

SERVICE DELIVERY

Service Model

Sobering-up shelters operate under a philosophy of harm minimisation. Harm minimisation is an approach that aims to reduce the adverse health, social and economic consequences of drug use by minimising the harms of drug use both for the community and the individual, without necessarily eliminating use.

The state of public, acute intoxication makes a person particularly vulnerable to harm. Sobering-up shelters provide a safe and caring place for the intoxicated person to remain during the sobering-up process.

The majority of clients admitted to sobering up shelter services are transported by NT Police or local community patrols. Referrals can also be made by a family member, responsible community member or a self-referral however not all SUS identified these as a source of admission. The decision to admit a self-referral is at the discretion of the care worker.

Care workers will monitor the person's state and ensure that any condition likely to result in harm to the person is minimised during the sobering-up process. In some cases this may mean that the client is referred to medical care.

The level of care to be expected is equivalent to what could be provided by a reasonably informed, concerned adult in a private community context.

The Shelter has a 'duty of care' to the intoxicated person who has agreed to be admitted to the shelter and will therefore try to ensure that the person is sober prior to leaving the shelter.

Service Delivery Principles

The Guidelines set out key principles that underpin sobering-up shelter service delivery. Specifically, they state that service providers and care work workers must:

- recognise the dignity, worth, independence, cultural diversity and basic human rights of all clients;
- apply principles of equity and accessibility to the service;
- be of appropriate agreed quality with respect to relevant professional practice, safety, risk, health outcomes and client interests; and
- develop and maintain collaborative relationships and referral linkages with other health and social services.

Service Delivery Key Performance Requirements

Under their respective funding agreements with the Department of Health, each service provider is required to have a comprehensive policy and procedure manual to ensure that the service model is documented, guidance on roles and responsibilities is readily available to staff, and that all levels of service meet agreed goals.

The Policy and Procedure manual must encompass:

- Contemporary HR policies, financial management, data collection and storage;
- Complaints and disputes;
- Occupational Health and Safety;
- A service wide smoke-free policy;
- Risk assessment and management for clients;
- Staff training and professional development; and
- Criminal history check for all staff working with vulnerable clients.

ACTIVITY DATA AND ANALYSIS

In the 2012/13 financial year, the Department of Health invested $2.57M in the delivery of sobering up shelter services.

During 2012, there were 17610 admissions to SUS services across the NT by 5239 clients. Based on a funding figure of $2.57M, this equates to an approximate direct cost of $145 per admission. This figure does not include costs of community patrols or resources used by NT Police to transport intoxicated people to sobering up shelters.

The combined bed capacity of all the sobering up shelters is 108.

A breakdown by individual service, showing current bed capacity and client admissions during 2012 is shown below:

Region	Beds	Number of admissions	Operating hours	Number of clients
Alice Springs	26	7,903	Only closed between 6am Sunday and 2pm Monday.	2294
Darwin	32	4,809	Monday to Saturday - open from 4pm to 8am next day.	1604
Katherine	18	3,610	Monday to Saturday - open from 4pm to 8am next day.	839
Nhulunbuy	16	320	Wednesday to Friday - open from 6pm to 7am next day.	118
Tennant Creek	16	968	Tuesday to Saturday – open from 4pm to 8am the next day.	384

During 2012, SUS services reported that the majority of clients were transported to their services by the NT Police, accounting for 76.61% of all clients. Night patrol services accounted for 21% whilst ‘other’ referrals, including self referrals, accounted for fewer than 2%.

Significantly, Alice Springs received only 2.8% of their 7903 admissions via the night patrol whereas Katherine’s night patrol service accounted for almost half (49.1%) of all clients transported to the SUS.

NT wide, the peak admission periods for SUS clients is between 7pm and 10pm, whilst peak periods for client discharges is between 5am and 7am.

The average length of admission ranges from 6 hours in Alice Springs through to 12.2 hours in Nhulunbuy. This figure is impacted upon by Alice Springs recording a stay of ten minutes or less for 44% of their total admissions.

Gender balance of clients varies across the NT. Males account for 54% of all Alice Springs admissions whilst in Darwin and Katherine they account for 70% of all admissions.

Of the 9702 brief interventions delivered during 2012, only 1636 clients were offered referral to a treatment service upon discharge. A view shared across the service providers is that the majority of referrals are refused and of those that accept a referral, many fail to attend follow up appointments.

During 2012, 2707 clients were admitted to a SUS on a single occasion only. This represents approximately 15% of all admissions. A small proportion of clients (5%) of all clients, were admitted 13 or more times (an average of once a month or more) and accounted for 33% of all admissions.

Rates of repeat client admissions vary across each SUS. In Katherine, 6.8% of their clients were admitted on more than 13 separate occasions throughout the reporting period. This cohort of clients accounted for 39.2% of Katherine's total admissions. In Tennant Creek, 1.8% (7 clients) accessed the service on more than 13 separate occasions, accounting for 16% of their admissions.

Repeat admissions statistics for each SUS during 2012 are shown in the table below

Region	Number of times admitted	Number of clients	Number of admissions	% of clients	% of admissions
Alice Springs	1	1,191	1,191	52	15
	2-4	698	1,830	30	23
	5-12	287	2,091	13	26
	13+	118	2,791	5	35
Darwin	1	871	871	54	18
	2-4	465	1,219	29	25
	5-12	199	1,360	12	28
	13+	69	1,455	4	29
Katherine	1	354	354	42	10
	2-4	280	758	33	21
	5-12	148	1,103	18	30
	13+	57	1,431	7	39
Tennant Creek	1	226	226	59	23
	2-4	108	273	28	28
	5-12	43	314	11	32
	13+	7	155	2	16
Nhulunbuy	1	65	65	55	20
	2-4	34	83	30	26
	5-12	15	115	13	36
	13+	4	58	3	18
TOTAL		5239	17610		

Criteria for entry and discharge

In accordance with the Sobering Up Shelter Guidelines, the decision on whether to accept a client into a sobering up shelter is based on an assessment of:

- the need of the intoxicated person for care;
- the capacity of the service to meet that need;
- level of physical aggression displayed; and
- the capacity of the intoxicated person to respond to questions and simple requests.

The guidelines state that the SUS will not admit clients who cannot stand up unaided. Clients must be able to walk unassisted from the police van or community patrol vehicle into the SUS. If a person cannot do this, then they are taken to the police cells or to hospital.

It is the SUS staff preference that police and night patrols take people to the cells instead of home as they are worried above the potential for domestic violence that may occur when returning an intoxicated person into a household.

Guidelines state that clients should be discharged when:

- They are no longer intoxicated;
- They are referred to another facility, service or person; or
- They decide to leave against staff advice and depart whilst intoxicated.

In the event that NT Police have transported a person to the shelter - and that person leaves whilst still intoxicated - notification is provided to Police. All shelters advise that this procedure is followed when a client absconds.

Entry via Police

Police follow internal policies and procedures regarding Protective Custody. The first option is to have the person placed in the care of a competent and willing friend or family member. If no such person is available, the next option will generally be the sobering up shelter. Clients delivered to the sobering up shelter must be able to walk unaided and be willing to remain at the shelter. Those clients who are unable to walk, will, in some instances, be assessed by Ambulance officers or be taken to hospital for assessment.

Persons refused entry by shelter staff or unable to be placed in the shelter because of the reasons outlined will then, as a last resort, be placed in Protective Custody at a Watch House[1].

[1] Email communication from A/Commander Wayne Harris, NT Police

Entry via Patrols
Procedures for transportation by community patrols appear to be a less structured, informal approach and vary across each region. The SUS should be the first point of call for intoxicated individuals picked up by the night patrol. Further investigation is warranted for protocols of each night/community patrol service in relation to transportation to a SUS. Where clients are transported home, the outcome needs further analysis to determine if there is any correlation in domestic violence rates.

In Tennant Creek, Julalikari Council reported that the night patrol transported over 15,500 people in the 2011/12 financial year. However, of this number, only 2% were taken to the SUS. Julalikari Council state that people do not like being taken to the SUS as the building is seen as being clinical, clients feel they are being judged and the service is not seen as very welcoming. Clients are given a wallet size card by the patrol service when they are taken to the SUS, so if a person needs to be picked up then they can ring the patrol service. The proportion of SUS admissions in Tennant Creek via the night patrol has increased from 7% in 2010 to 26% in 2012.

Entry via family/self
Under the section titled “Admission, Care and Discharge”, the guidelines state that “clients are brought to the sobering up shelter by Police, Night Patrol, recognised agencies, responsible community member, self (at the discretion of care worker)”

With the exception of Tennant Creek, which reported ‘other‘ as a source of referral for 16% of all admissions, all shelters received approximately 99% of their admissions from NT Police or the local community patrol.

SUS as a place of safety
Section 63 of the *Volatile Substance Abuse Prevention Act* (VSAPA) provides for the declaration of a designated place of safety. This enables persons apprehended under Part 2, Division 3 of the VSAPA to be transported and held for their own safety. Declaration of a place of safety requires a formal application process, Ministerial approval and gazettal.

Darwin, Alice Springs and Tennant Creek were gazetted in 2008 and declaration processes for Katherine and Nhulunbuy are currently underway. Designating a premise as a place of safety under the VSAPA also enables people to seek shelter if they are not intoxicated but at risk of domestic or personal violence.

Procedures for managing a client who is using the SUS as a place of safety under the VSAPA, need to be clearly articulated in the revised SUS Guidelines.

Hours of Operation
Each sobering up shelter operates on days and times as determined by their respective Service Level Agreements. The table below illustrates the operating hours and days for each SUS.

Region	**Operating times**
Darwin	Monday to Saturday - open from 4pm to 8am next day.
Katherine	Monday to Saturday - open from 4pm to 8am next day.
Nhulunbuy	Wednesday to Friday - open from 6pm to 7am next day.
Tennant Creek	Tuesday to Saturday - open from 4pm to 8am next day.
Alice Springs	Service **only** closes between 6am Sunday and 2pm Monday.

Throughout the consultation process, the majority of SUS service providers and other stakeholders repeatedly stated that a better service could be provided if services received additional funding to increase their operating hours, employ more staff, allow time for training and increase the number of beds in their facility.

It was identified that each of the five services had days and times of peak demand periods and other times where there were very low client admissions. Rather than provide additional funding to expand the operating hours to enable the delivery of a 24/7 service, it is recommended that each service work with the AODP to determine appropriate operating hours and days to ensure the efficient provision of services during peak demand periods and the effective use of staff time during low occupancy periods.

The 'maximum occupancy' tables contained in Appendix 2 for each SUS analysis support the recommendation to better align operating hours with time of peak demands.

Realignment of the operating hours will support a more coordinated approach to client discharge, allowing greater engagement with outreach workers and treatment service providers. The continued practice of discharging clients as early as 6AM, does not allow appropriate referral or meaningful follow-up. The implications of an early morning discharge will be assessed as part of a realignment of operating hours.

Realigning the operating hours to ensure peak demand times are adequately catered for, will need to be managed in consultation with SUS Managers, community patrols, NT Police, treatment service providers and other stakeholders.

Brief interventions prior to discharge

It is stated in the SUS Guidelines that Care Workers should "routinely provide an opportunity for clients to raise issues related to their alcohol and other drug use and, if requested, negotiate appropriate referral for ongoing assistance, support and/or treatment."

For the six month period July to December 2012, the delivery of brief interventions (BI) to clients admitted to the respective SUS services was reported as follows:

	Brief Intervention provided					
	No	**Yes**	**Total**	**No**	**Yes**	**Total**
Alice Springs	3160	453	3613	87%	13%	100%
Darwin	2112	192	2304	92%	8%	100%
Katherine	478	1290	1768	27%	73%	100%
Nhulunbuy	89	14	103	86%	14%	100%
Tennant Creek	142	311	453	31%	69%	100%
Total	**5981**	**2260**	**8241**	**73%**	**27%**	**100%**

Whilst it is not mandated to deliver a brief intervention to **every** client admitted to the SUS, less than half of all admitted clients actually partake in one. Given the characteristics of the client base and the voluntary nature by which they enter and exit the service, it is not reasonable to expect that every client will be involved in a discussion related to their alcohol and other drug use. In reviewing the SUS guidelines and performance reports in collaboration with service providers and stakeholders, it is suggested that a more realistic and achievable figure for the provision of brief interventions be agreed upon.

Of all admissions during 2012, only 13% received referral to a treatment service provider upon discharge.

	Darwin	**Alice Springs**	**Katherine**	**Nhulunbuy**	**Tennant Creek**	**Total**
Not Referred	7477	4535	2362	285	839	15498
Referred	423	349	1277	36	129	2214
Total admissions	7900	4884	3639	321	968	17712
% referred	**5%**	**7%**	**35%**	**11%**	**13%**	**13%**

It is significant to note that one individual SUS made 1277 referrals, accounting for 57% of all referrals, with the other four services accounting for the remainder. Significantly, the service with the 1277 referrals stated during consultation that the majority of clients refuse or fail to attend these referrals.

Without an appropriate referral and follow up process, it is not possible to determine the effectiveness of the referral practices, in terms of improved client outcomes, for each individual SUS. Any changes or improvements in this area should take into account the capacity of the wider treatment services to accommodate additional referrals.

Referral Pathways

Referral pathways currently exist between sobering up shelters, treatment service providers and other organisations which may be able to provide additional support and assistance to the client. Based on available evidence and anecdotal advice from each of the services, the use of these pathways is very limited and where utilised, follow-up is minimal. One service noted the difficulty in making and following up referrals for clients. This is despite the same organisation having responsibility for managing the Sobering Up Shelter, the residential rehabilitation service and transitional aftercare service in the region.

The majority of SUS service providers identified difficulties with their referral processes, often compounded by different working times between the SUS and other treatment services.

The referral procedure to other agencies needs to be clearly established with each shelter. Given that treatment and care services will often have clients in common, the opportunity exists to coordinate care to enhance service quality, comprehensiveness and continuity for clients.

Referral procedures should be specified in a Memorandum of Understanding (MOU) negotiated with each referring agency. The process of negotiating a MOU will ensure that there is a shared understanding of the roles and responsibilities of each agency, particularly in relation to the process itself, client confidentiality and clarifying follow-up procedures.

During consultation with the Darwin SUS, it was stated that "….the continued pursuit of the homeless without offering a suitable solution to their plight is a waste of resources and finances, which require continued delivery without any viable outcomes on the horizon." This can be overcome through an effective and well managed referral process to a range of treatment services based on the individual client's needs.

It is recommended that the SUS Services engage with local stakeholders to build regional communication and collaboration within the sector, specifically dealing with the challenges and constraints of referral processes and practices from the respective SUS services. It is proposed that this be coordinated by AODP to ensure a consistent approach that is aligned to Service Level Agreements and which informs amendments to the referral process contained with the current guidelines.

Increasing the capacity of sobering up shelters to provide appropriate and timely referrals for treatment, advice and support must be a key priority for service providers and government. This will go a long way to improving client outcomes through encouraging clients to seek additional support for their alcohol misuse and guiding them through the process where possible.

The *Alcohol Mandatory Treatment Act* commenced on 1 July 2013. It provides for residential rehabilitation for people who are repeatedly taken into police custody as a result of chronic alcohol misuse.
There is no referral path to mandatory treatment from the Sobering Up Shelters under this legislation. This maintains the policy intent of clients voluntarily choosing to access the SUS for care. However, for those clients with chronic alcohol misuse and multiple SUS admissions each year, there is concern amongst SUS providers that these clients could benefit from treatment but are choosing not to accept the offers made of referral into treatment.

Further consideration of providing treatment for identified clients with numerous SUS admissions is warranted.

Training and Development

The provision of training and development activities for SUS Care Workers was raised by each service as a significant issue. Currently, Care Workers are required to possess a current First Aid certificate (or be willing to obtain one within six months of commencement) and enrol in a Certificate III in Community Services.

The Guidelines state that if workers do not possess a qualification in alcohol and other drugs work they are required to undertake the Certificate III in Community Services (Alcohol and Other Drug Work) and accredited units in Managing Intoxicated People and Brief Interventions during their first two years of employment.

Currently, there are 31 Care Workers undertaking formal studies directly linked to their employment. Nineteen are undertaking a Certificate III and 12 are undertaking the Certificate IV.

In the past two years, a total of 71 individual Certificate level training units have been completed by Care Workers. In the same period, five Care Workers have completed Certificate III and two have completed Certificate IV.

Four Care Workers who have completed the Certificate III studies have enrolled to undertake the Certificate IV.

Service providers consulted during the review identified that the need to undertake formal study and the associated demands, are impacting upon retention and subsequently, services are experiencing a high turnover of staff, further compounding the problem of inexperienced and untrained workers.

Services recognised that the completion of certain elements in the Certificate III program that should be given priority and that completion of the qualification should be undertaken in a specified timeframe; be actively monitored and sponsored by the Shelter; and linked to a salary increment.

Competencies that should be undertaken as a priority are:

- Work effectively in the Alcohol and Other Drug sector;
- Provide brief intervention;
- Work with clients who are intoxicated;
- Use targeted communication skills to build relationships; and
- Work effectively with culturally diverse clients and co-workers

In addition, staff in the Tennant Creek service stated that **PART** (predict, assess and respond to) would be beneficial to those working in SUS and were also critical of the training modules, stating that "….whoever wrote the modules had clearly not worked or experienced work in a shelter". The Katherine service agreed that **PART** would be appropriate and should be supported by internal and external training days and where possible, coverage could be provided by a pool of trained temporary staff.

The Nhulunbuy service stated that the Department of Health had been very supportive in assisting with concerns and enquiries in relation to training and development opportunities. It was further stated that and relevant training and information was regularly provided by local DoH staff.

All services agreed that greater access to training and workshops would enhance progression towards formal qualifications for Care Workers. All services saw a key role for the service Manager in providing appropriate mentoring and identifying and supporting the completion of training and development opportunities.

Gender balance of staff

The sobering-up shelter guidelines provide clear direction on staffing levels with particular reference to personal qualities, skills and gender.

The Guidelines specifically state that a Sobering Up Shelter will employ and roster an adequate number of care workers who are well informed, supported and trained to manage and care for intoxicated persons.

Staffing levels of the sobering-up shelter should be sufficient at all times for the requirements of the service:

- staffing levels should be at least two staff for every shift, at least one who is qualified in first aid;
- the gender of staff should reflect the gender of clients accommodated;
- increased staffing on shifts should be proportionate to extra beds occupied;
- extra staff should be called in at busy times; and
- clear guidelines should outline the circumstances necessary to call in extra staff.

Service providers all spoke of the benefits and challenges in ensuring Care Worker gender balance during the conduct of a normal shift. It is noted that the recruitment of female Care Workers is identified as a significant challenge in some regions, particularly Tennant Creek and Katherine.

This should not impede normal effective operations, albeit allowances and procedures should be put in place to ensure the integrity of the workforce and protection of the client. For instance, a practice was evident in Katherine when, in the absence of a female Care Worker, the Shelter would not accept female clients.

There is a distinct need for ensuring the provision of gender-appropriate services, particularly given the level of intoxication and increased vulnerability of clients.

The provision of services to female clients varies across all regions and this is compounded by the difficulty in attracting and retaining female staff with appropriate skills, knowledge and experience.

Use of hand held breath testing devices

During consultation with service providers, the use of hand held breath testing devices in each SUS was discussed. Whilst acknowledging that taking a sample of a client's breath under these conditions is voluntary, the use of these devices as a properly utilised tool could value add to the care of the client.

The device could be utilised to measure the level of intoxication in clients at both intake and exit from the shelter. The use of a hand held breath-testing devices can be used (as one measure) to check if the client is intoxicated or not, upon entry to the Shelter. This is significant as the client's impairment may be due to head trauma, other drug use or poly drug use and may require medical attention and/or appropriate strategies to enhance their care.

The device can also be used prior to discharge to determine Blood Alcohol content and can assist in determining whether the client has the capacity to receive and benefit from a brief intervention or referral to a service provider.

The Tennant Creek SUS currently utilise hand held devices however there is no clear policy or guidance in place to identify how the use of such devices can improve services to clients. With the exception of Alice Springs, all other SUS services would welcome their introduction on the basis that guidance and direction in their use (and appropriate responses) is provided.

Services operating in other jurisdictions reported the use of hand held breath testing devices upon admission and prior to discharge. This enabled them to better assess the level of intoxication, manage client risk and to enable appropriate care planning.

Guidelines on the use of approved, Australian Standard hand held devices (including the implications for readings and appropriate action) would need to be developed and clearly communicated.

It is recommended that the use of hand held breath testing unit be investigated as part of a trial program to determine whether their use is an effective tool in measuring intoxication and assisting in determining appropriate client care options.

Self-referral policy

This is an issue which requires clarification in all shelters.

Under the section titled “Admission, Care and Discharge”, the guidelines state that “clients are brought to the sobering up shelter by Police, Night Patrol, recognised agencies, responsible community member, self (at the discretion of care worker)”

The Guidelines further state that “clear guidelines and training should be provided to assist staff to make decisions about whether or not a person should be admitted to the shelter, refused admission or referred elsewhere.”

If the Care Worker is expected to make an informed decision on whether or not to accept a self-referral, they need to be adequately trained in assessing the level of care that the person requires. This will ensure the decision on whether or not to admit a client is based on an understanding of the client’s needs and the capacity of the shelter to provide appropriate care.

Whilst the decision to accept a ‘self-referral’ rests with the care worker however it is clear that there are differing views and approaches between shelters. The Alice Springs SUS service does not accept self–referrals, however for the Tenant Creek SUS, 16% of their total admissions in 2012 were self-referrals.

Self-referral clients should be seen as an opportunity to appropriately engage, conduct a brief intervention and, where appropriate, arrange referral to a suitable treatment service provider upon discharge.

Given the pressure placed on SUS staff during peak periods, self-referral for the purposes of using the SUS purely as a homeless shelter needs to be tactfully but strongly refused.

Where possible, referral to an appropriate housing services provider must be encouraged.

Short term admissions

Regardless of their mode of transport to a sobering up shelter, clients are able to leave at any time, regardless of their level of intoxication or degree of impairment. There is no policy requirement or legislative basis upon which to mandate people into the care of the sobering up shelter.
Guidelines *suggest* that an intoxicated person should receive care for a period of at least six hours - however this is determined on an individual basis.
Given that the primary existence of sobering up shelters is to provide a safe place for intoxicated people at risk of harm to sober up, short term admissions do not contribute to achieving this outcome.

This is highlighted by data provided by the Alice Springs SUS for the 2012 calendar year. During this period, 3,438 admissions (44% of all admissions) were for periods of 10 minutes or less. A further six per cent of admissions recorded a length of stay between 10 minutes and one hour. It is strongly recommended that AODP explore and trial strategies to encourage clients to remain at the SUS until they are sober.

The Darwin service stated that the introduction of a 24 hour, 7 day a week staffed service receiving clients around the clock (and with the provision of a security guard/Police presence), would ensure that numbers of “departing while intoxicated” would be dramatically reduced.

The Darwin shelter also noted that the change from a 2.00pm opening to a 4.00pm opening has had a massive impact on the number of “absconds” from SUS in the afternoon shifts. With the 6 hour determination period clients are aware that if they enter the SUS after 4.00pm then the take away alcohol distributors will all be shut when they can *legitimately* leave the SUS so they tend to stay for longer periods, thus keeping them in a safe environment until they sober up.

During the consultation process, NT Police advised that when contacted about a client absconding from a SUS in Alice Springs, Katherine and Darwin, a BOLF (be on the lookout for) is issued and a unit dispatched *if in the area*.
This arrangement does not occur in Tennant Creek or East Arnhem. There are no statistics available to determine the occurrence and/or return of the client to the shelter or to police protective custody if still intoxicated.
Given the nature of policing and demand for scarce resources, it could reasonably be expected that a client leaving the shelter is a low priority.

Reception and record keeping

It is a requirement that each SUS maintain confidential, accurate and up-to-date client records in accordance with agreed standards. To support this, each service is required to develop a records management policy that covers:

- Staff responsibility for maintenance of the records system;
- Guidelines and standards for staff in completing records; and
- Confidentiality issues.

Sobering up shelters are required to collect and record information on a Sobering Up Shelter Computerised System provided by the Department of Health. This enables data to be extracted and analysed to determine occupancy rates, bed utilisation rates, duration of admission, referrals to other services and frequency of individual client admissions.

The data is used for internal reporting purposes and is also used to measure progress against performance measures specified in Service Level Agreements. In order to make the data more meaningful, Service Level Agreements must be reviewed to ensure that the performance measures are linked to the quality of the service provided, not simply a statistical summary of activities. Whilst some SUS services provide comprehensive commentary on client outcomes and activities, others provide bare minimum numbers.

Further compounding this inability to effectively measure and compare service outcomes across each SUS is the difference in reporting criteria, as not all services report on the same activities or outcomes.

It is recommended that the data collected and reported upon by each SUS be reviewed to ensure appropriateness and consistency across each service and to ensure it is clearly linked to performance reporting requirements.

Refresher training must be provided to all existing staff and a process to train all new staff in the use and value of computerised record systems within a set period of their commencement.

Provision of meals

Currently, there is a significant variance in the provision of meals for clients prior to discharge from the respective shelters ranging from a fully cooked meal through to the provision of cereal, toast and a hot beverage.

Contained within the SUS Guidelines there is clear advice on breakfast choices to ensure thiamine rich food is provided (or at least offered) to clients exiting the SUS. The guidelines state that ‘a person should be encouraged to have a nutritious meal, a drink of water and/or a hot drink and a 100mg thiamine tablet for those who are at the shelter for alcohol intoxication’.

Further, the guidelines state ‘that the food offered should be rich in thiamine and chose with reference to the recommended nutritional requirements of an adult’.

There is no requirement under the current service agreements to record whether a client was offered and/or provided with a meal prior to discharge.

Services in other jurisdictions

As part of the review process, sobering up shelters in other jurisdictions was consulted in relation to their service delivery model, client outcomes and challenges.

Where face to face consultation was not possible, written documentation was sought on policy, operational procedures, reporting frameworks and challenges in delivering a client focussed service.

A written response was provided by the following services:

- City Mission (Launceston, Tasmania)
- Walangari Sobering Up Shelter (Broome, WA)
- CatholicCare Canberra and Goulburn Sobering Up Shelter (ACT)
- Salvation Army Bridge Programme (Perth, WA)

A site visit was undertaken by Mr John Daulby to the Salvation Army Sobering Up Shelter in Whitmore Square, Adelaide. Mr Daulby's comments and observations are incorporated into the report.

The Western Australia Drug and Alcohol Office provided a copy of their "Guidelines for The Operation of Sobering Up Centres" for information.

A summary of each service's charter is provided in Appendix 3.

APPENDIX 1

CONSULTATION LIST

Alcohol and Drugs Services Central Australia

Alcohol and Drugs Services Darwin

Alice Springs Hospital - Accident and Emergency

Barkly Region Alcohol and Drug Abuse Advisory Group

CatholicCare Canberra

Central Australia Aboriginal Alcohol Programmes Unit

City Mission Serenity House

Drug and Alcohol Services Association

East Arnhem Shire Council

Gove District Hospital – Accident and Emergency

Julalikari Council Aboriginal Corporation - Night Patrol

Julalikari Council Aboriginal Corporation - Council of Elders and Respected Persons

Kalano Aboriginal Corporation - Venndale Rehabilitation Centre

Katherine Hospital - Accident and Emergency

Mission Australia

Nhulunbuy Alcohol and Other Drugs Rehabilitation Service

Northern Territory Police

Salvation Army

Tangentyere Council Patrol Service

Tennant Creek Hospital - Accident and Emergency

Warangari Sobering Up Shelter

Western Australia Drug and Alcohol Office

APPENDIX 2

STATISTICAL SUMMARY FOR EACH SOBERING UP SHELTER

Alice Springs

Darwin

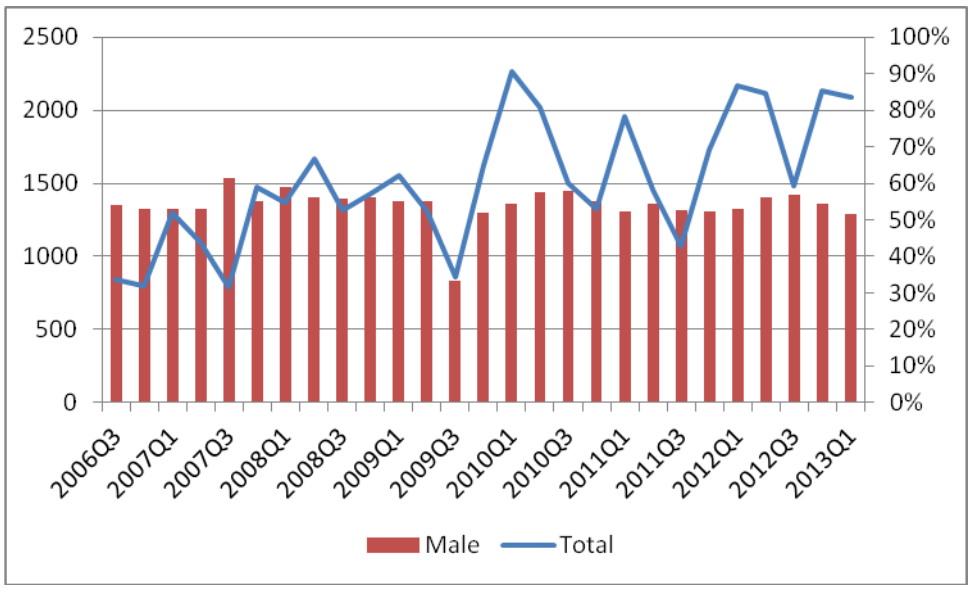
Nhulunbuy

Katherine

Tennant Creek

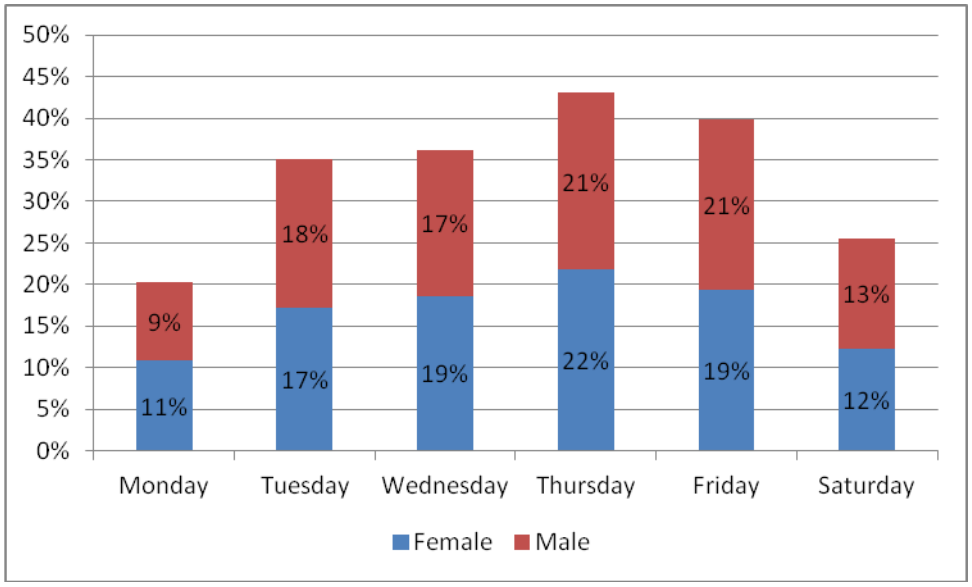
Activity summary for Alice Springs SUS 2012

Figure 1: Number of admissions and percent male by quarter, Alice Springs SUS, 2006 to 2012.



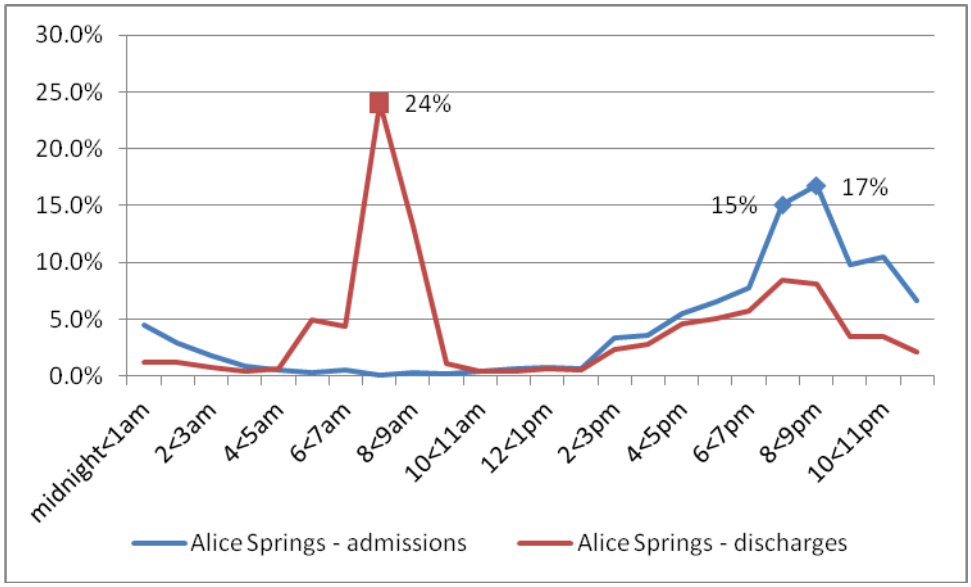
- Total admissions to Alice Springs SUS have increased over the period shown at a rate of approximately 40 admissions per quarter.
- Males accounts for 54% of all admissions over the period shown, ranging from 51% to 61% of admissions per quarter (excluding 2009 Q3 as an outlier).

Figure 2: Proportion of admissions by gender and day of the week, Alice Springs SUS, 2012.



- Admissions in 2012 peaked on Thursdays, 22%, with a minimum on Mondays, 10%.
- The male and female proportions are largely unaffected by day of the week.
- Note that in this chart the day is the day on which the admission commenced, e.g. 'Monday' includes all admissions that commenced on Monday and where the discharge was a Monday or Tuesday.

Figure 3: Admissions and discharges by hour of the day, Alice Springs SUS, 2012.



- Admissions peak between 7pm and 9pm, 32%.
- Discharges peak between 7am and 8am, 24%.
- In 2012, each hour between 3am and 2pm accounted for less than 1% of all admissions. A total of 5.4% of all admissions occurred between these hours.
- Between 2pm and midnight the pattern of discharges mirrors the pattern of admissions at a lower overall level. This reflects the relatively high level of short-term admissions shown below.

Table 1: Length of stay in days by year, Alice Springs SUS, 2012.

Year	Number of admissions	Average length of stay in hours	Proportion of admissions less than 10 minutes	Number of admissions >10 minutes
2007	4,658	8.6	12%	4102
2008	5,783	6.9	21%	4562
2009	5,338	8.3	23%	4084
2010	7,111	8.7	31%	4938
2011	6,214	9.1	27%	4525
2012	7,903	6.0	44%	4465

- In 2012 Alice Springs SUS recorded 3,438 admissions with a length of stay of 10 minutes or less, 44% of the total number of admissions recorded.
- This proportion has increased from 12% in 2007.
- A further 6% of admissions in 2012 recorded a length of stay of between 10 minutes and 1 hour.
- The number of admissions with a length of stay greater than 10 minutes has increased since 2007 but declined between 2010 and 2012.

Table 2: Source of referral, Alice Springs SUS, 2012.

	Police	Patrol	Other	Number of admissions
2007	92.9%	6.5%	.7%	4,658
2008	95.8%	3.7%	.5%	5,783
2009	94.2%	4.9%	1.0%	5,338
2010	95.5%	3.7%	.7%	7,111
2011	93.9%	5.3%	.8%	6,214
2012	95.6%	2.8%	1.6%	7,903

- Police have accounted for 93% or more of admissions since 2007.

Table 3: Multiple admissions, Alice Springs SUS, 2012.

Number of times	Number of clients	Number of admissions	% of clients	% of admissions
1	1,191	1,191	52	15
2-4	698	1,830	30	23
5-12	287	2,091	13	26
13+	118	2,791	5	35
Total	2,294	7,903	100	100

- In 2012, 52% of clients recorded one admission for the year, accounting for 15% of all admissions.
- 5% of clients were admitted on 13 or more occasions, accounting for over one third (35%) of admissions.

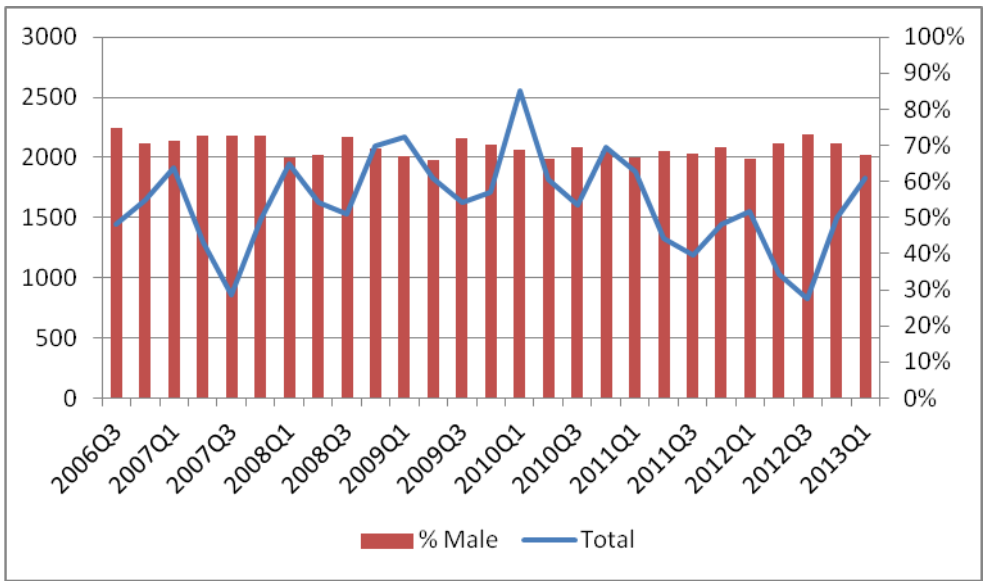
Table 4: Maximum occupancy, Alice Springs SUS, 2012.

Maximum Occupancy	No of times reached within period	% of overall times
20	1	0
17	3	1
16	5	2
15	4	1
14	10	3
13	13	4
12	20	7
11	15	5
10	27	9
9	31	10
8	33	11
7	33	11
6	32	10
5	23	8
4	20	7
3	17	6
2	14	5
1	4	1
Total	**305**	**100%**

- Alice Springs SUS reported a total of 305 operating days in 2012.
- It reached a maximum of 20 occupied beds on one day and an occupancy of 13 (half the available beds) or less beds on 92% of days.
- Note that this analysis does not account for length of stay; it includes admissions of short duration as described above and which may not have actually occupied a bed. It also does not account for gender distinctions in bed allocation.

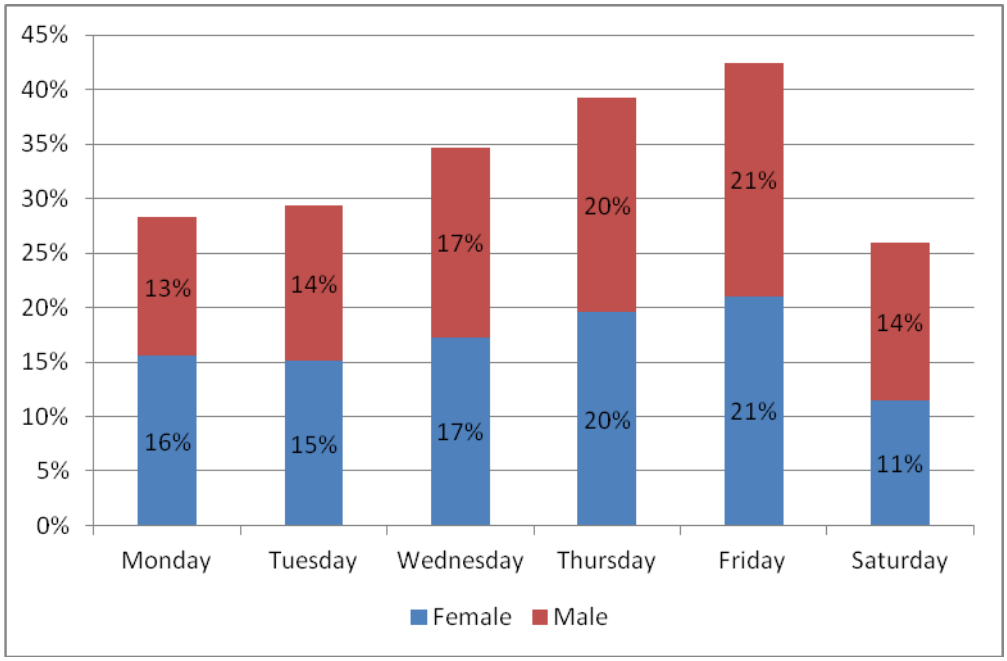
Activity summary for Darwin SUS 2012

Figure 4: Number of admissions and percent male by quarter, Darwin SUS, 2006 to 2012.



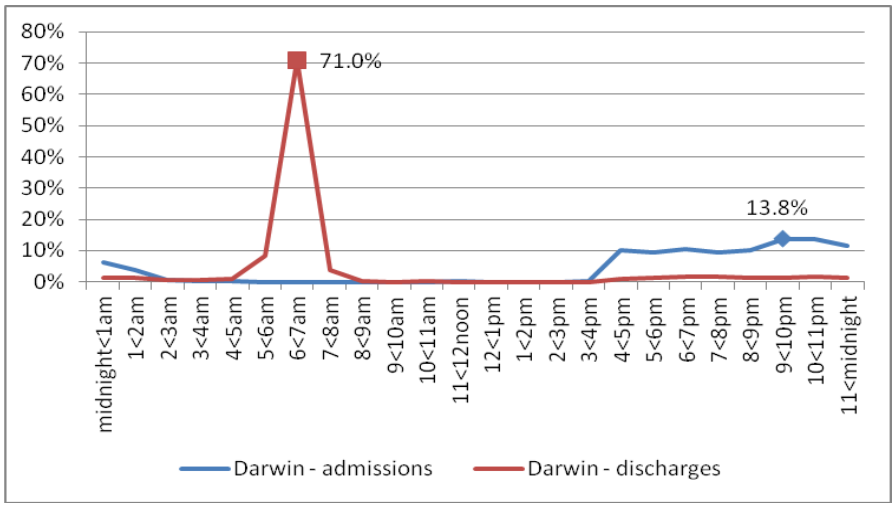
- Total admissions to Darwin SUS have fluctuated over the period, showing an overall decline of about 7 admissions per quarter.
- Males accounts for 70% of all admissions over the period shown, ranging from 66% to 75% of admissions per quarter.

Figure 5: Proportion of admissions by gender and day of the week, Darwin SUS, 2012.



- Admissions in 2012 peaked on Thursdays, 21%, with minimums on Mondays and Saturdays of 14%.
- The male and female proportions are largely unaffected by day of the week.
- Note that in this chart the day is the day on which the admission commenced, e.g. 'Monday' includes all admissions that commenced on Monday and where the discharge was a Monday or Tuesday.

Figure 6: Admissions and discharges by hour of the day, Darwin SUS, 2012.



- Admissions peak between 9pm and 10pm, 14%.
- Discharges peak between 6am and 7am, 71%.

Table 5: Length of stay in days by year, Darwin SUS, 2012.

Year	Number of admissions	Average length of stay in hours	Proportion of admissions less than 10 minutes	Number of admissions >10 minutes
2007	5,560	8.1	5%	5269
2008	7,197	8.0	5%	6838
2009	7,338	9.7	4%	7051
2010	8,049	8.8	5%	7679
2011	5,844	8.8	5%	5560
2012	4,809	9.7	4%	4601

- In 2012 Darwin SUS recorded 208 admissions with a length of stay of 10 minutes or less, 4% of the total number of admissions recorded.
- This proportion has been stable over time.
- The average length of stay in hours across all admissions has fluctuated but generally increased over time.

Table 6: Source of referral, Darwin SUS, 2012.

	Police	Patrol	Other	Number of admissions
2007	99.0%	0.3%	0.7%	5,560
2008	85.0%	13.7%	1.3%	7,197
2009	76.6%	22.2%	1.1%	7,338
2010	78.6%	19.8%	1.6%	8,049
2011	75.6%	23.4%	1.0%	5,844
2012	68.4%	30.7%	1.0%	4,905

- Police have accounted for the majority of admissions in each year since 2007 although this proportion has declined from 99% to 68% while the proportion accounted for by Patrols has increased.

Table 7: Multiple admissions, Darwin SUS, 2012.

Number of times admitted	Number of clients	Number of admissions	% of clients	% of admissions
1	871	871	54.3	17.8
2-4	465	1,219	29.0	24.9
5-12	199	1,360	12.4	27.7
13+	69	1,455	4.3	29.7
Total	1,604	4,905	100	100

- In 2012, 54% of clients recorded one admission for the year, accounting for 18% of all admissions.
- 4% of clients were admitted on 13 or more occasions, accounting for just less than one third (30%) of admissions.

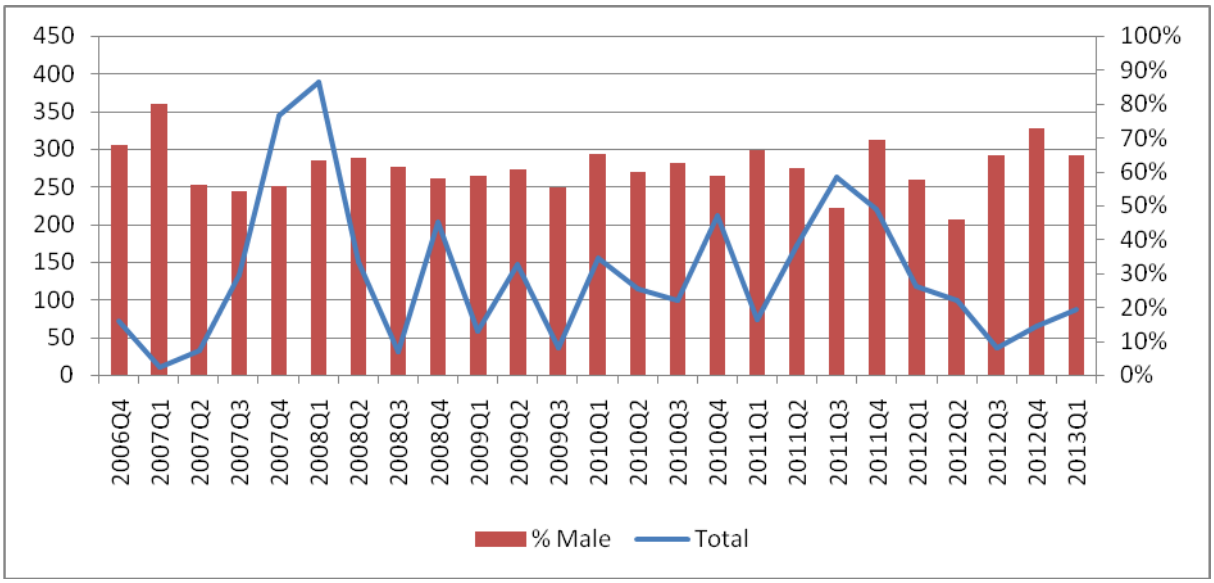
Table 8: Maximum occupancy, Darwin SUS, 2012.

Maximum Occupancy (All)	No of times reached within period	% of overall times
24	1	0
22	2	1
21	2	1
20	4	1
19	6	2
18	5	2
17	8	3
16	12	4
15	15	5
14	22	7
13	20	6
12	21	7
11	27	9
10	16	5
9	19	6
8	30	10
7	18	6
6	32	10
5	19	6
4	10	3
3	10	3
2	8	3
1	2	1
Total	**309**	**100%**

- Darwin SUS reported a total of 309 operating days in 2012.
- It reached a maximum of 24 occupied beds on one day and an occupancy of 16 (half the available beds) or less beds on 91% of days.
- Note that this analysis does not account for length of stay; it includes admissions of short duration as described above and which may not have actually occupied a bed. It also does not account for gender distinctions in bed allocation.

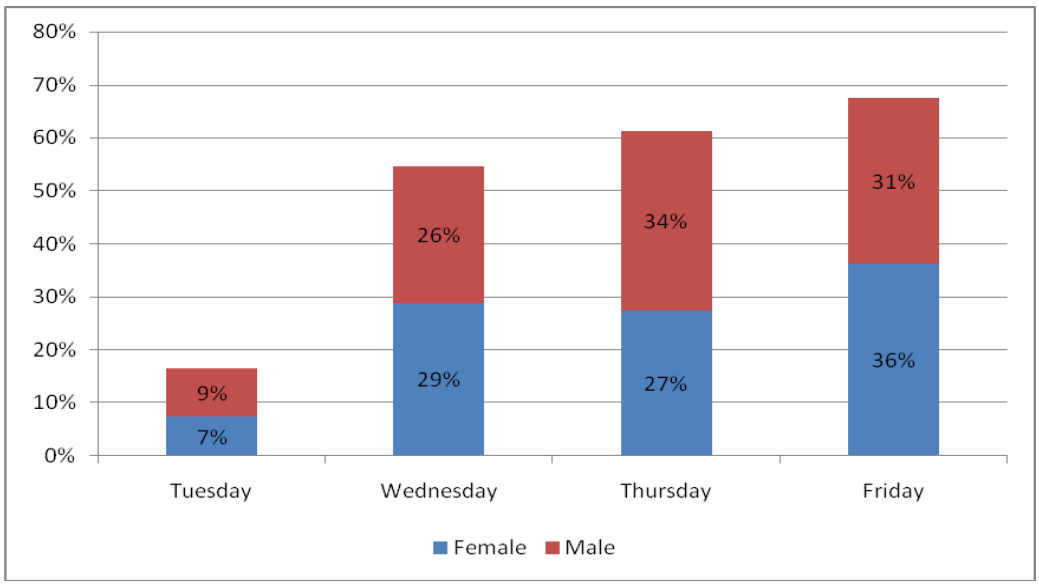
Activity summary for Nhulunbuy SUS 2012

Figure 7: Number of admissions and percent male by quarter, Nhulunbuy SUS, 2006 to 2012.



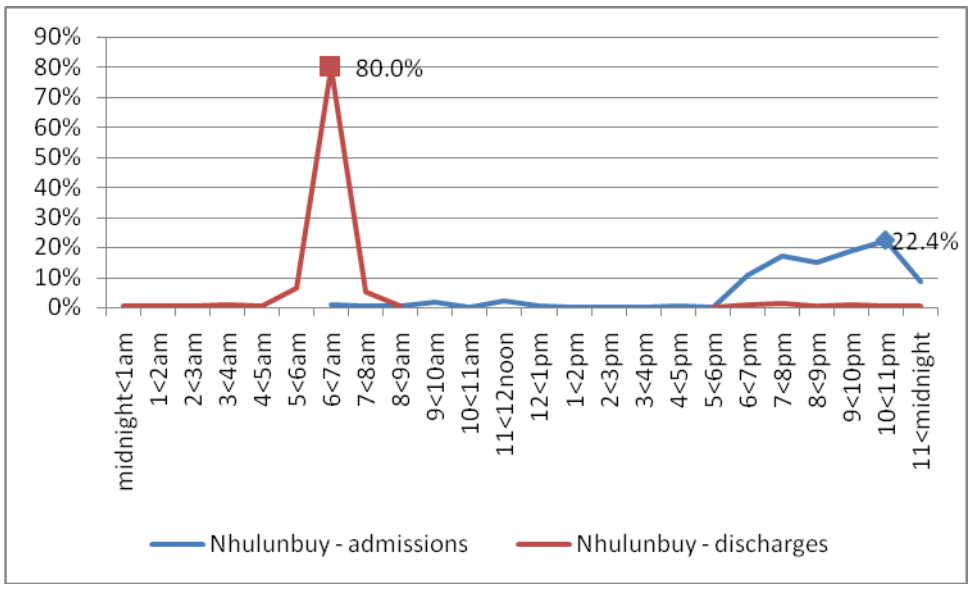
- Total admissions to Nhulunbuy SUS have fluctuated around an average of approximately 130 admissions per quarter over the period shown.
- Males accounts for 60% of all admissions over the period shown, ranging from 46% to 80% of admissions per quarter.

Figure 8: Proportion of admissions by gender and day of the week, Nhulunbuy SUS, 2012.



- Admissions in 2012 peaked on Fridays, 33%, with a minimum on Tuesdays, 8%.
- The male and female proportions are largely unaffected by day of the week, although females were more likely to be admitted on Fridays and males on Thursdays.
- Note that in this chart the day is the day on which the admission commenced, e.g. 'Wednesday' includes all admissions that commenced on Wednesday and where the discharge was a Wednesday or a Thursday.

Figure 9: Admissions and discharges by hour of the day, Nhulunbuy SUS, 2012.



- Admissions peak between 7pm and 9pm, 22%.
- Discharges peak between 6am and 7am, 80%.

Table 9: Length of stay in days by year, Nhulunbuy SUS, 2012.

Year	Number of admissions	Average length of stay in hours	Proportion of admissions less than 10 minutes	Number of admissions >10 minutes
2007	519	7.6	6%	489
2008	775	8.0	1%	765
2009	241	8.4	1%	239
2010	581	na	0%	581
2011	730	19.5	2%	719
2012	320	12.2	1%	318

- In 2012 less than 1% of admissions to Nhulunbuy SUS recorded a length of stay of 10 minutes or less.
- The average length of stay for admissions has increased in 2011 and 2012 compared to earlier years.

Table 10: Source of referral, Nhulunbuy SUS, 2012.

	Police	Patrol	Other	Number of admissions
2007	53.6%	19.8%	26.6%	519
2008	41.2%	22.2%	36.6%	775
2009	30.7%	6.6%	62.7%	241
2010	5.5%	93.3%	1.2%	581
2011	12.2%	85.8%	2.1%	730
2012	8.1%	91.0%	0.9%	321

- In 2012, 90% of admissions were accounted for by Patrols.

Table 11: Multiple admissions, Nhulunbuy SUS, 2012.

Number of times	Number of clients	Number of admissions	% of clients	% of admissions
1	65	65	55.1	20.2
2-4	34	83	28.8	25.9
5-12	15	115	12.7	35.8
13+	4	58	3.4	18.1
Total	118	321	100	100

- In 2012, 55% of clients recorded one admission for the year, accounting for 20% of all admissions.
- 3% of clients were admitted on 13 or more occasions, accounting for over one fifth (18%) of admissions.

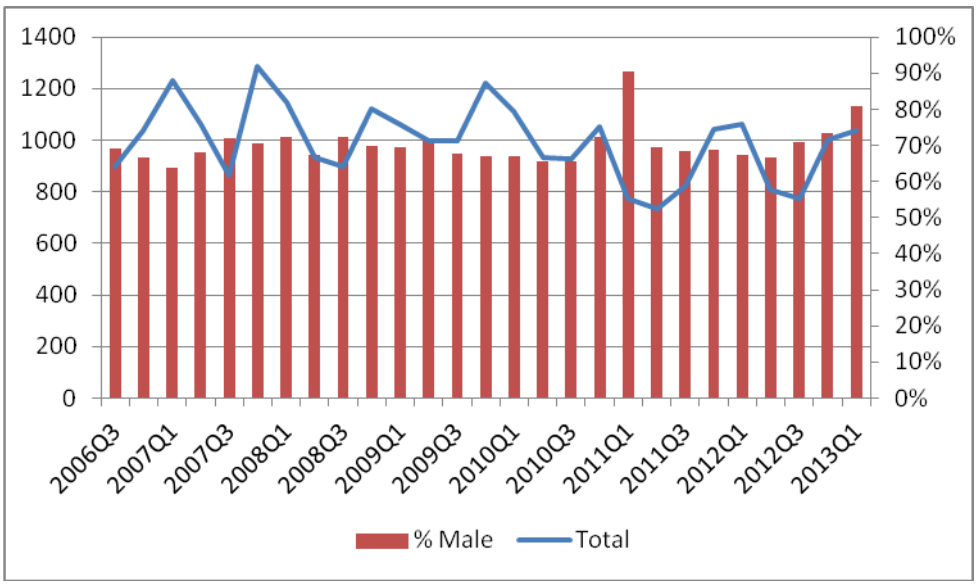
Table 12: Maximum occupancy, Nhulunbuy SUS, 2012.

Maximum Occupancy (All)	No of times reached within period	% of overall times
12	1	1
8	4	4
7	2	2
6	3	3
5	3	3
4	12	12
3	19	19
2	27	28
1	27	28
Total	**98**	**100%**

- Nhulunbuy SUS reported a total of 98 operating days in 2012.
- It reached a maximum of 12 occupied beds on one day and an occupancy of 8 (half the available beds) or less beds on 97% of days.
- Note that this analysis does not account for length of stay; it includes admissions of short duration as described above and which may not have actually occupied a bed. It also does not account for gender distinctions in bed allocation.

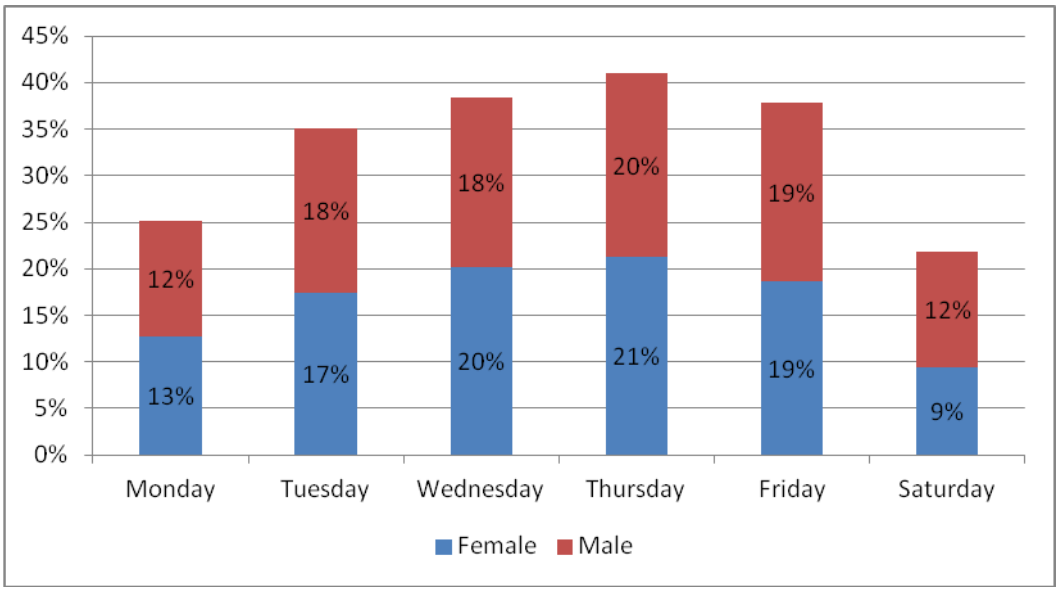
Activity summary for Katherine SUS 2012

Figure 10: Number of admissions and percent male by quarter, Katherine SUS, 2006 to 2012.



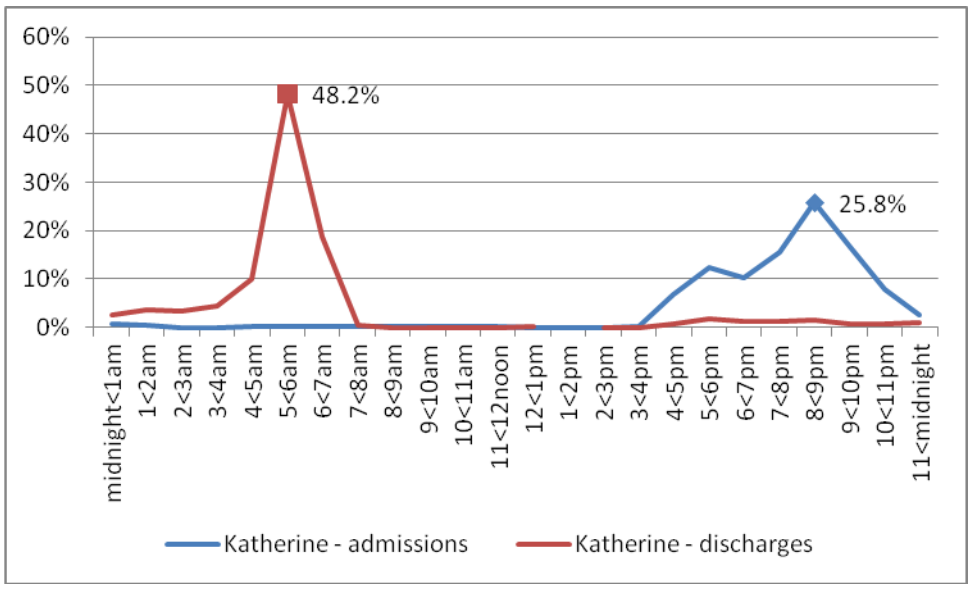
- Total admissions to Katherine SUS have declined slightly over the period shown at a rate of approximately 7 admissions per month.
- Males accounts for 70% of all admissions, ranging from 64% to 90% of admissions per quarter.

Figure 11: Proportion of admissions by gender and day of the week, Katherine SUS, 2012.



- Admissions in 2012 peaked on Thursdays, 20%, with a minimum on Saturdays, 12%.
- The male and female proportions are largely unaffected by day of the week.
- Note that in this chart the day is the day on which the admission commenced, e.g. 'Monday' includes all admissions that commenced on Monday and where the discharge was a Monday or Tuesday.

Figure 12: Admissions and discharges by hour of the day, Katherine SUS, 2012.



- Admissions peak between 8pm and 9pm, 26%.
- Discharges peak between 5am and 6am, 48%.
- Compared to other shelters, admissions to Katherine increase to a peak and then decline fairly rapidly.

Table 13: Length of stay in days by year, Katherine SUS, 2012.

Year	Number of admissions	Average length of stay in hours	Proportion of admissions less than 10 minutes	Number of admissions >10 minutes
2007	4,441	20.0	2%	4363
2008	4,098	11.2	1%	4047
2009	4,280	9.3	1%	4231
2010	4,028	13.4	1%	3996
2011	3,370	8.8	2%	3318
2012	3,610	10.8	3%	3506

- In 2012 Katherine SUS recorded 104 admissions with a length of stay of 10 minutes or less, 3% of the total number of admissions recorded.
- This proportion has been stable since 2007.
- The number of admissions with a length of stay greater than 10 minutes has fluctuated since 2007.

Table 14: Source of referral, Katherine SUS, 2012.

	Police	Patrol	Other	Number of admissions
2007	55.0%	44.6%	0.4%	4,441
2008	55.7%	44.1%	0.2%	4,098
2009	49.3%	50.4%	0.3%	4,280
2010	53.6%	45.9%	0.5%	4,028
2011	51.4%	48.4%	0.2%	3,370
2012	50.8%	49.1%	0.1%	3,646

- Police and Patrols have accounted for approximately 50% of admissions each since 2007.

Table 15: Multiple admissions, Katherine SUS, 2012.

Number of times	Number of clients	Number of admissions	% of clients	% of admissions
1	354	354	42.2	9.7
2-4	280	758	33.4	20.8
5-12	148	1,103	17.6	30.3
13+	57	1,431	6.8	39.2
Total	839	3,646	100	100

- In 2012, 42% of clients recorded one admission for the year, accounting for 10% of all admissions.
- 7% of clients were admitted on 13 or more occasions, accounting for 4 out of 10 (39%) admissions. This is the highest proportion for this group amongst the five shelters.

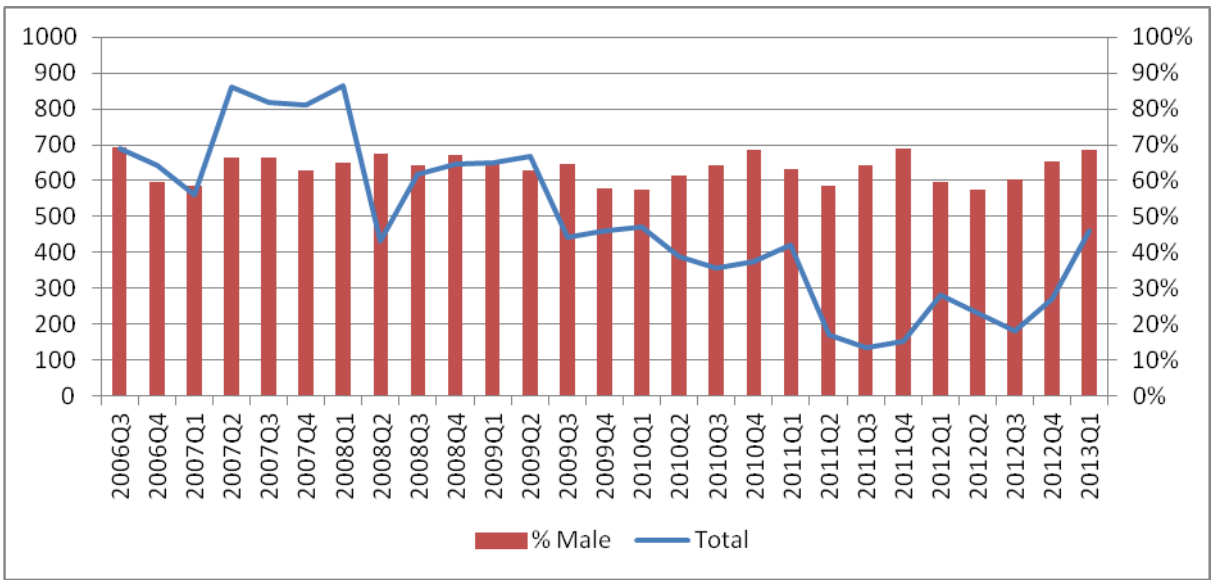
Table 16: Maximum occupancy, Katherine SUS, 2012.

Maximum Occupancy (All)	No of times reached within period	% of overall times
21	1	0
17	4	1
16	4	1
15	10	3
14	17	6
13	24	8
12	21	7
11	29	10
10	28	9
9	33	11
8	24	8
7	24	8
6	16	5
5	17	6
4	21	7
3	11	4
2	8	3
1	9	3
Total	**301**	**100%**

- Katherine SUS reported a total of 301 operating days in 2012.
- It reached a maximum of 21 occupied beds on one day and an occupancy of 9 (half the available beds) or less beds on 54% of days.
- Note that this analysis does not account for length of stay; it includes admissions of short duration as described above and which may not have actually occupied a bed. It also does not account for gender distinctions in bed allocation.

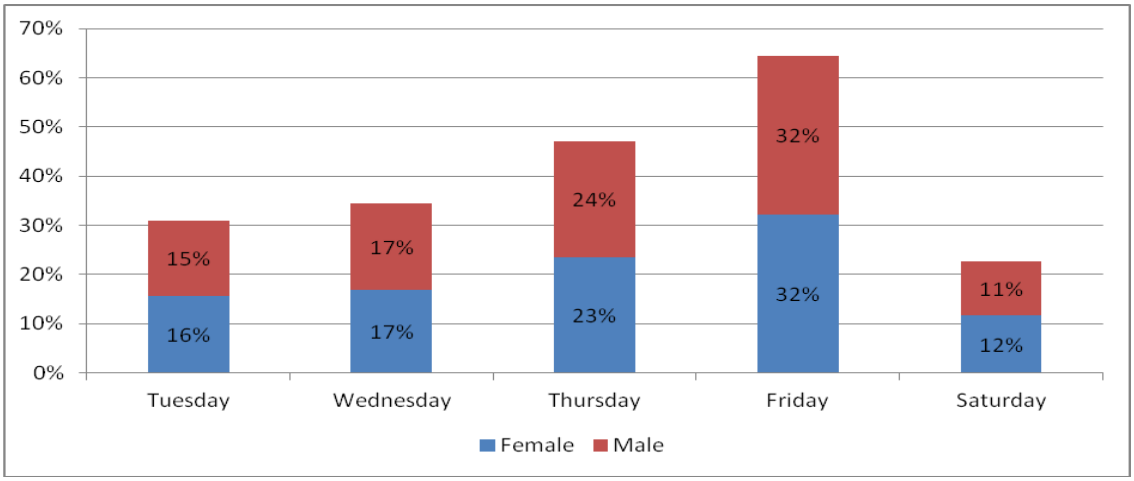
Activity summary for Tennant Creek SUS 2012

Figure 13: Number of admissions and percent male by quarter, Tennant Creek SUS, 2006 to 2012.



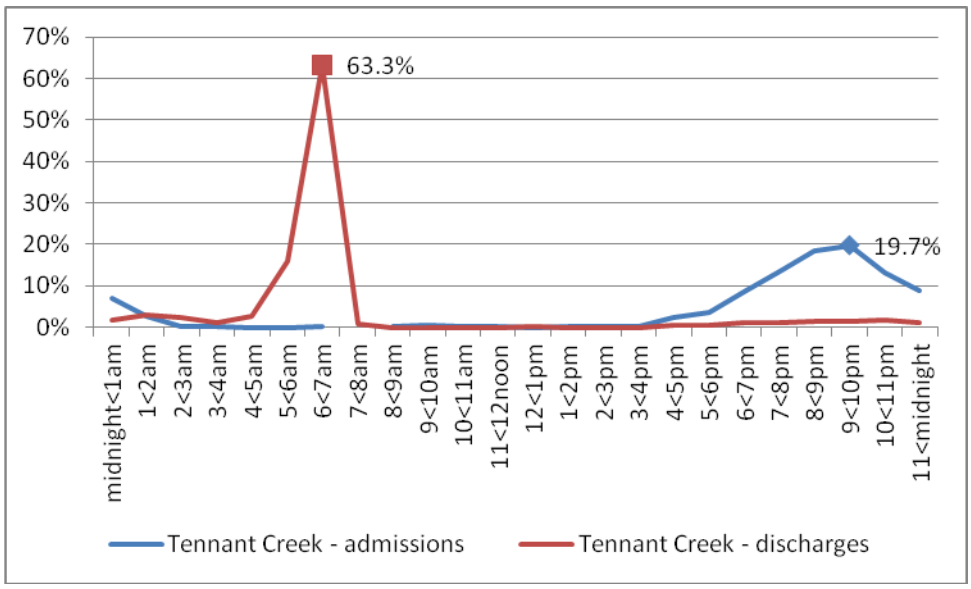
- Total admissions to Tennant Creek SUS have declined over the period shown at a rate of approximately 23 admissions per quarter.
- Admissions declined during 2011 and the early part of 2012 due to building renovations and the temporary relocation of the service but may be showing a recent return to 2010 levels.
- Males accounts for 63% of all admissions over the period shown, ranging from 58% to 69% of admissions per quarter.

Figure 14: Proportion of admissions by gender and day of the week, Tennant Creek SUS, 2012.



- Admissions in 2012 peaked on Fridays, 32%, with a minimum on Saturdays, 11%.
- The male and female proportions are largely unaffected by day of the week.
- Note that in this chart the day is the day on which the admission commenced, e.g. 'Monday' includes all admissions that commenced on Monday and where the discharge was a Monday or Tuesday.

Figure 15: Admissions and discharges by hour of the day, Tennant Creek SUS, 2012.



- Admissions peak between 9pm and 10pm, 20%.
- Discharges peak between 6am and 7am, 63%.

Table 17: Length of stay in days by year, Tennant Creek SUS, 2012.

Year	Number of admissions	Average length of stay in hours	Proportion of admissions less than 10 minutes	Number of admissions >10 minutes
2007	3,048	11.5	1%	3016
2008	2,561	21.0	1%	2536
2009	2,220	12.5	2%	2179
2010	1,589	13.8	2%	1565
2011	883	9.6	3%	859
2012	968	8.3	3%	939

- In 2012 Tennant Creek SUS recorded 968 admissions with a length of stay of 10 minutes or less, 3% of the total number of admissions recorded.
- This proportion has increased slightly from 1% in 2007.
- The number of admissions with a length of stay greater than 10 minutes has declined markedly since 2007.

Table 18: Source of referral, Tennant Creek SUS, 2012.

	Police	Patrol	Other	Number of admissions
2007	92.4%	2.0%	5.6%	3,048
2008	95.5%	0.5%	3.9%	2,561
2009	92.5%	1.9%	5.6%	2,220
2010	79.4%	7.2%	13.4%	1,589
2011	63.0%	28.8%	8.3%	883
2012	57.5%	26.3%	16.1%	968

- In 2012, Police accounted for 57% of admissions and Patrols for 26%.
- Police have accounted for 93% or more of admissions since 2007.
- Sixteen per cent of admissions were self referrals (recorded under 'other' in this table), by far the largest proportion among shelters.

Table 19: Multiple admissions, Tennant Creek SUS, 2012.

Number of times	Number of clients	Number of admissions	% of clients	% of admissions
1	226	226	58.9	23.3
2-4	108	273	28.1	28.2
5-12	43	314	11.2	32.4
13+	7	155	1.8	16.0
Total	384	968	100	100

- In 2012, 59% of clients recorded one admission for the year, accounting for 23% of all admissions.
- 2% of clients were admitted on 13 or more occasions, accounting for 16% of admissions.

Table 20: Maximum occupancy, Tennant Creek SUS, 2012.

Maximum Occupancy (All)	No of times reached within period	% of overall times
14	1	0
11	4	2
9	3	1
8	3	1
7	13	6
6	14	6
5	23	10
4	37	16
3	33	14
2	54	24
1	44	19
Total	**229**	**100%**

- Tennant Creek SUS reported a total of 229 operating days in 2012.
- It reached a maximum of 14 occupied beds on one day and an occupancy of 8 (half the available beds) or less beds on 92% of days.
- Note that this analysis does not account for length of stay; it includes admissions of short duration as described above and which may not have actually occupied a bed. It also does not account for gender distinctions in bed allocation.

APPENDIX 3

SOBERING UP SHELTERS IN OTHER JURISDICTIONS

CITY MISSION TASMANIA

The City Mission operates 4 beds (2 in Burnie, 2 in Launceston) under the following service delivery principles:

- A safe, monitored tired environment for clients to sober up;
- Operates a 24 hours 7 day a week service;
- Provision of appropriate referral and information on a range of options available in the community in consultation with the client;
- Work in collaboration with both the client and other agencies to help establish ongoing case management support;
- Friendly and professional staff will spend time with each person to explore issues surrounding their drug and/or alcohol usage.

Referrals to the shelter come from a variety of sources, including, but not limited to:

- Self-referral
- Family
- Police
- Friends
- Medical practitioners
- The regional alcohol and drug sector
- Community organisations

The target group are voluntary clients aged 18 and above who require a safe, supported and supervised environment to sober up from the effects of alcohol and/or other drugs.

It is a written policy of the organisation that the Aboriginal and Torres Strait Islander community is a priority target in all alcohol and other drug related interventions.

Clients who do not receive assistance from City Mission are those who:

- appear to suffer from significant, untreated injuries that require medical assessment, observation and/or treatment;
- require mental health treatment, intervention and/or assessment;
- are not intoxicated and/or drug affected;
- display violent, aggressive or unmanageable behaviour; and
- do not wish to be in a sobering up facility.

A Drug and Alcohol Client Assessment form is completed for all clients.

A hand held breath analyser is used to determine a client's BAC entry upon admission. The machine is serviced and maintained by the Tasmanian Police Service.

Details of suitable and available services are discussed with clients once sober and the client is involved in deciding which treatment option is the most appropriate. Referral processes are in place to support this.

If a client exits the facility before sobering up, staff must contact Police and inform them of the client's departure and approximate whereabouts,

Staff may provide a simple and nutritious meal to clients when sober and prior to discharge.

Care Workers require a minimum of Certificate IV in Community Services (or willingness to obtain) and a Workplace Level 2 First Aid Certificate.

A Policy and Procedures Manual is available for all staff and components are reviewed annually. All sections of the manual contain 'Last Date of Review' and 'Next Date of Review'.

SALVATION ARMY BRIDGE PROGRAMME WA

The Salvation Army facility operates a 14 bed service in Perth allowing for 10 male clients and 4 female clients at any one time.

The service does not provide counselling, however information is provided to clients in relation to the Salvation Army's detox and rehabilitation services and other service providers in the Region.

There is no follow up process for clients at the Shelter, however the service provider also operates a non-residential service which offers counselling on a weekly or fortnightly basis. Clients exiting the shelter are encouraged to attend.

Breath analysis machines are used to measure BAC upon admission and prior to discharge.

Clients receive a meal, have their clothes washed and dried, are given a shower and provided with a bed to sleep in.

Clients can attend the service for three consecutive days but are then required to have at least a two day break before their next admission.

WALANGARI SOBERING UP SHELTER WA

The Walangari Sobering Up Shelter operates a 26 bed facility in Broome, allowing for 16 male clients and 10 female clients at any one time.

The service operates under the jurisdiction of the Milliya Rumurra Rehabilitation Centre, 11kms from Broome.

The shelter does not provide counselling to clients.

Care Workers, with approval from clients, can submit a referral request to the CHMR (Cyrenian House Milliya Rumurra) Outreach Team. The Outreach team visits the shelter each Friday morning for two hours and supports those clients wishing to undertake treatment at the Milliya Rehabilitation centre in Broome or Cyrenian House in Perth.

The majority of clients opting for rehabilitation choose the local Broome option.

The CHMR Team also undertake home visits in Broome, Aboriginal communities along the Dampier Peninsula and to Bidyadanga, south of Broome.

The Shelter uses an alcohol breath testing device upon admission. Sober persons are not admitted.

CATHOLICCARE SOBERING UP SHELTER ACT

The service aims to screen all clients on exit using either the Alcohol Use Disorder Identification Test (AUDIT) or the electronic version of the Alcohol Smoking Substance Involvement Screening Tool (e-ASSIST).

The two screening tools provide a measurement for the level of substance use and form a basis for staff to provide a brief intervention.

Clients are offered a referral on exit, however the service states that due to the nature of the client base, there is a low uptake of referrals.

The service does not have a dedicated outreach worker however where possible, they offer telephone support for up to 3 months post discharge.

The services utilises an alcohol breath testing device at both admission and exit from the shelter. This provides information on the level of intoxication and can indicate high tolerance or dependence. Use of the device is voluntary and it is explained to clients that taking a BAC reading enables appropriate care to be provided and for record keeping purposes. Policy and procedures have been developed to guide its use by Care Workers.

For the period January to December 2012, approximately 500 clients accessed the service. Of these:

- 92% of clients exiting the service were screened using one or both of the tools;
- 60% of all clients received a brief intervention;
- 1% agreed to be referred to a treatment service provider; and
- 6.7% received a follow up telephone call.

SALVATION ARMY SOBERING UP SHELTER SOUTH AUSTRALIA

The Salvation Army operates a 30 bed facility in Whitmore Square, Adelaide allowing 20 male and 10 female clients at any one time. The SUS employs twelve staff – 4 full time and 8 permanent part-time. The service operates 24 hours a day, 7 days a week.

Staff at the SUS must be enrolled in Certificate IV Alcohol and Other Drugs and the majority of training is provided by SA TAFE.

The primary objective of the SUS is to provide a safe, monitored environment for intoxicated people that may be at risk of harm to themselves or others.

The SUS takes 'walk-in' clients and with frequent users of the service, makes a concerted effort to engage the client and work with them towards accessing other services. Clients, primarily, must be coherent and able to walk unassisted, If significantly intoxicated, a visual assessment is made and when appropriate, a breath test is conducted. If highly intoxicated, medical intervention is sought. The SUS has been using hand held breath testing devices for approximately 8-9 years.

The SUS has no 'kick-out' time and clients are encouraged to sleep as long as possible, take fluids and have a meal. Breakfast provides an opportunity for positive engagement.

The busiest times in the SUS are between 3pm and 3am.

Generally, clients are not provided pyjamas and sleep in their own clothes. A client has the option to access shower facilities and have their clothes laundered.

The SUS does not have a policy to ban or exclude clients however there is a level of respect expected. If a client fails to co-operate, he or she is asked to leave and if unwilling, Police are requested to assist.

The SUS does follow-ups when the client is known to them and has previously engaged with other programs. The service principle is based on gaining the trust of clients to support encouragement into treatment services and counselling programs.

PILL TESTING

The 2013 Australian Institute of Health and Welfare's National Drug Strategy Household Survey reported 27% of Australians aged 20-29 had used illicit drugs in the preceding 12 months, with 8% having used ecstasy in that period. The 2015 United Nations World Drug Report found Australians had the highest rate of ecstasy consumption on earth.

Ecstasy, one of the drugs usually associated with music festivals and often referred to as 'pingers', 'eckies', 'pills' and 'molly', contains the stimulant drug MDMA. However, a lot of drugs and pills sold as ecstasy in fact contain little to no MDMA. Instead, they contain a mix of other drugs and fillers such as household cleaning products, which makes it difficult for consumers to judge the consequences of consuming the drug. In Australia in the past year seven people have died from taking drugs at music festivals.

A harm-reduction approach to drugs is always a balance between benefits and risks: the availability of pill testing reduces harm, but it may increase risks for some. Not everyone will use the service and some may ignore the results and risk being subject to potentially harmful drugs. It may also lend the appearance of safety when, in reality, the pills remain illegal and potentially harmful.

Pill testing is not a radical idea. As a harm-reduction intervention provided by community and local governments, it is available in several European countries including the Netherlands, Switzerland, Austria, Belgium, Germany, Spain and France. The European Union has had their peak drug body produce best practice guidelines to do drug checking.

Research shows young people are highly supportive of pill testing; more than 82% of the 2,300 young Australians aged between 16 and 25 years surveyed for the Australian National Council on Drugs in 2013 supported its introduction. The finding is consistent with young people's overall views about drugs: they want better information in order to make informed choices.

Pill testing has been shown to change the black market. Products identified as particularly dangerous that subsequently became the subject of warning campaigns were found to leave the market. Research also shows the ingredients of tested pills started to correspond to the expected components over time. This suggests pill testing might be able to change the black market in positive ways.

Pill testing has shown to change behaviour: research from Austria shows 50% of those who had their drugs tested said the results affected their consumption choices. Two-thirds said they wouldn't consume the drug and would warn friends in cases of negative results.

Visits to pill testing booths can create an important opportunity for providing support and information over and above the testing itself. They enable drug services to contact a population that is otherwise difficult to reach because these people are not experiencing acute drug problems. In some European countries pill testing has been used to establish contact and as the basis for follow-up work with members of not-yet-problematic, but nevertheless high-risk, groups of recreational drug users.

Pill testing can capture long-term data about the actual substances present in the drug scene. It can create the potential for an early warning system beyond immediate users. This is becoming all the more important as new psychoactive substances that may be used as adulterants are appearing more frequently.

There has been mixed reaction to introducing pill testing in Australia. Professor Alison Ritter of the National Drug and Alcohol Research Centre and Dr Alex Wodak, President of the Australian Drug Law Reform Foundation, have argued that pill testing should be introduced in Australia for the reasons mention above. Politicians throughout Australia have taken the view to reduce harm through the promotion of drug-free events with the appropriate police resources to enforce the law and having medical staff on site.

It has been suggested that having a trial of pill testing should occur to evaluate its effectiveness in Australia. Currently the law in jurisdictions throughout Australia does not allow pill testing to occur as there is insufficient evidence to guarantee the safety of taking drugs. The consequences of allowing the consumption of substance that cause harm could have legal implications in the case of death caused by the taking of drugs.

The key focus and priority area for the Northern Territory Government is the emerging prevalence of crystallised methamphetamine (ice) use and the continued misuse of alcohol, tobacco and cannabis.

In February 2016, the Northern Territory Government launched the 'Break the Ice' webpage that contains the Northern Territory Ice Action Plan – Tackling Ice in the Northern Territory, and also provides detailed information on:

- the harms that arise from ice
- treatment and support options for individuals, their friends, their family members and the broader community
- supply reduction activities
- proposed activities and strategies to minimise the harms from the use of ice.

This is complemented by a campaign designed to educate people about the potential harms and ultimately, reduce demand for and use of the drug, particularly among young people.

In addition to the work being done within government departments, there are also many non-government organisations that are funded by government to provide services to enhance the level of support, prevention and treatment options for those affected by alcohol and other drug addiction.

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