Executive Summary

This report reflects a **Demand Study of Alcohol Treatment Services in the NT.** It is a mixed-methods research project examining the current NT alcohol treatment services system. It provides an assessment of how much treatment is currently provided; how much should be provided to meet current demand; and the challenges, barriers and opportunities associated with the planning and delivery of alcohol treatment services in the NT. It responds to multiple recommendations outlined in the *NT Alcohol Policies and Legislation Review* (Riley, 2017); and a subsequent Northern Territory Government (NTG) commitment to undertake the study in the *NT Alcohol Harm Minimisation Action Plan 2018-2019* (NTG 2018). It also responds to a recent report about the social and economic costs and harms of alcohol consumption in the Northern Territory (NT), about the need for a comprehensive alcohol treatment services system (Smith, Whetton, & d'Abbs, 2019).

The project is modelled on two recent national demand studies. The first was completed by DPMP and involved a review of treatment service systems across Australia (Ritter et al., 2014). The second was completed by the National Drug Research Institute (NDRI) and involved a qualitative analysis of treatment services involving Aboriginal and Torres Strait Islander people (Gray et al., 2014). The research design has been adapted to meet the unique population distribution, geography and service delivery context of the NT.

This study has been led jointly by Menzies School of Health Research and the Drug Policy Modelling Program (DPMP) at the University of New South Wales, and in partnership with the Aboriginal Medical Services Alliance of the NT (AMSANT).

There were **42,871 episodes/encounters for alcohol treatment in NT in 2016/17**, equating to 117 encounters every day across the NT. Aboriginal and Community Controlled Health Organisation (ACCHO) episodes represent the highest number of encounters (41%). The next highest is GP encounters (18%). Self-help also comprises a substantial amount of alcohol treatment in the NT (16%). Brief interventions provided as part of Sobering Up Shelters (SUS) represent the fourth highest number of episodes/encounters (13%). This is a signal that these settings are vital for picking up and referring people into more intensive alcohol treatment pathways.

The subsequent analysis of unmet demand shows that there is currently a **relatively small gap between met and unmet demand** for alcohol treatment in the NT. It also highlights some areas of additional focus. Key findings reveal:

- There is a large unmet demand for screening and brief intervention, in the order of 18,500 to 19,000 people
- The provision of alcohol treatment (as described in the DASPM care packages), estimates 6,735 people need to be treated in any one year, representing an unmet demand gap of around 2,000 people aged between 18 and 64 years.
- There are currently 158 residential rehabilitation beds provided in the NT for people with alcohol disorders. This is 15% below the modelled estimate of 187 residential rehabilitation beds.

- The level of clinical FTE predicted to meet the care as specified in DASPM is well above the current clinical FTE in the NT. This suggests that while the numbers of people being treated may be about right, the intensity and the level of care is not configured in a way that might best meet needs.
- More treatment is required to respond to mild and moderate needs.

The qualitative component provides a descriptive account of key stakeholder viewpoints from across the alcohol treatment services system. This includes a discussion about alcohol treatment types, including preventative health interventions, brief interventions, counselling, withdrawal services, day programs, residential rehabilitation services and continuing care. The perceived strengths and gaps of each are discussed. A descriptive account of the factors impacting demand; pathways into treatment; intersections with treatment referrals from the criminal justice system; a discussion about the implications of remoteness on treatment accessibility in the NT; and the need for targeted workforce development, are also included.

A comprehensive strategy is required, that includes alcohol treatment services to curb these costs. Typically, alcohol treatment services are defined as clinical interventions such as withdrawal, counselling, residential rehabilitation and pharmacotherapy. However, a broader definition would include a broader range of interventions, such as brief interventions in primary care, and social and emotional wellbeing services provided in the context of reducing alcohol consumption.

Key Messages

The key messages presented below have been aligned with the research objectives associated with this study.

Use of Alcohol Treatment Services

- The gap between the numbers of people currently receiving alcohol treatment in the NT, and the projected total demand for alcohol treatment is relatively small.
- There were 42,871 episodes/encounters for alcohol treatment in NT in 2016/17, with ACCHOs delivering 41% of treatment provision, including culturally focused social and emotional wellbeing services. GP encounters represent 18% of treatment; with self-help and SUS equating to 16% and 13% of treatment provision respectively. This shows that at least 88% of alcohol treatment service delivery is provided in settings outside of a specialist care system.
- The majority of treatment is in the form of non-residential counselling (58% episodes of care) followed by Brief Interventions (35% of all episodes of care).
- Residential Rehabilitation Services (RRS) equate to 3.2% of treatment episodes, and provide a more intensive treatment option for some clients with severe alcohol dependence; these clients usually also concurrently experiencing challenges with housing and/or other vulnerabilities.
- Of the 42,871 total episodes of care, it is estimated that between 6,400 and 7,997 individuals receive treatment in the NT in any one year for alcohol-related problems. This represents around 2.8% of the NT population. This equates to 5.3 episodes to 6.7 episodes per person per year.
- The vast majority of the 'specialist' alcohol treatment (provided by NTG, hospitals and specialist NGOs) is provided in Alice Springs (45%) and Darwin (42%).
- The experience of service providers suggests that RRS are being used as a means to secure temporary housing and accommodation for clients (particularly those clients exiting detention or seeking refuge from DFSV), rather than the primary focus of providing intensive treatment and therapeutic support. An increased investment in supported accommodation and public housing options, to complement alternative community-based alcohol treatment options, is worth further investigation.

Demand for Alcohol Treatment Services

- There is a large unmet need for screening and brief intervention, mostly delivered in non-specialist treatment settings by GPs, primary health care providers, ACCHOs and self-help groups. There is significant potential to address this unmet need by highlighting the potential of these non-specialist treatment settings to assist people with problematic alcohol use.
- Innovative and culturally responsive treatment approaches were frequently discussed by interviewees. The modelled projection of total demand for alcohol treatment in any one year (excluding screening and brief intervention) was between 5,723 and 7,745 people. This modelled projection of demand for treatment is consistent with the number of people currently receiving alcohol treatment in the NT.
- Strategies to build local workforce capacity and/or recruit and retain capable staff are important areas for investment. The modelled estimate from DASPM predicted 187 residential rehabilitation beds; there are currently 158 residential rehabilitation beds available in the NT for people with alcohol disorders. Further investigation of optimal bed usage is needed for future service planning.

Pathways into Treatment

- The most common pathway into treatment is self-referral combined with cross-referral between services.
- Motivation to begin treatment include influence by significant others or service providers, or due to legal matters.
- The Health Pathways project being implemented by NTPHN will provide useful information about clinical decision-making about AOD treatment referral pathways between acute and community-based treatment services, such as those offered by GPs and ACCHOs. This may guide the development of future treatment pathways; and may also help to identify under-utilised pathway options, with subsequent workforce development requirements.

Referrals from the Criminal Justice System

- According to the AODTS National Minimum Data Set (which represents 8% of alcohol treatment episodes), RRS is the most common referral pathway used by the criminal justice system, followed by assessments and counselling. Using a three-year average, there are 209 closed episodes of RRS per year resulting from community-based Corrections referrals; and 85 closed episodes of RRS per year resulting from lawyer referrals.
- The 'other' category for source referrals from Corrections (as defined through MHAOD ESPCS) represents the highest proportion of referrals across all treatment types. This is problematic for understanding exactly who is making a referral. Further investigation about who is represented as 'other' is warranted. This has implications for service planning.
- The establishment of a more robust alcohol treatment service response within (rather than external to) the Corrections systems is warranted. This is particularly important for sex and serious violent offenders, where there is a clear service gap.
- An exploration of ways to promote more cost-effective treatment options for clients transitioning into, and out of, the criminal justice system is warranted. This could include more intensive family support programs to prevent child removal, including targeted alcohol harm minimisation strategies; and restorative justice practices combined with community-based alcohol treatment programs.
- Integrated approaches between health, housing, and justice systems to support clients entering and exiting alcohol treatment services are important. There are some examples of intensive throughcare and case management support being provided, but are heavily reliant on an appropriate supply of accommodation.

Implications of Remoteness

- Hospital, withdrawal or RRS (located in larger towns) or culturally focused programs (located on outstations) reflect a small proportion of the current treatment service system in the NT.
- For those living remotely, the costs of travel to major urban centres can be a barrier to accessing these intensive models of treatment.
- Interview data indicates that:
    - Transport costs can be a barrier for, and in some instances there is inadequate funding to support, Fly-in Fly-Out/Drive-in Drive-Out alcohol treatment service delivery to remote and very remote locations.
    - Community-based treatment options are highly valued, particularly for clients with mild and moderate needs. This applies to both urban and remote contexts.

- The use of technological options, such as tele-health, could be significantly enhanced to meet the needs of remote clients with alcohol-related health concerns.

AOD Treatment Service System Workforce Considerations

- The intergenerational nature of alcohol-related trauma in the NT, particularly among Aboriginal clients, requires both generalist and specialist skill development across the alcohol treatment services system.
- The NTPHN has recently commissioned an NT AOD Workforce Strategy to identify the needs of the specialist NGO AOD workforce. However, the workforce needs of specialist government services and non-specialists such as GPs, primary health care providers, ACCHOs and volunteers with self-help groups, must also be considered in order to meet the unmet demand for brief interventions and screening, particularly for people with mild and moderate alcohol concerns.

Improving Data Systems

- Further work is required to promote and track the use of AUDIT-C in primary health care settings, particularly among GPs. This may help to increase referrals between GPs and alcohol treatment services. It will also aid future analyses of alcohol treatment demand.
- Episodes of care by region are difficult to ascertain for ACCHOs through the Online Services Report (OSR). This is a significant limitation for regional health planning across the NT and highlights the importance of reviewing and improving the OSR data system.
- This study should be seen as the first comprehensive approximation of met and unmet demand for alcohol treatment services in the NT. It provides new data for treatment services planning, and has highlighted ways to improve future estimations.

For further information about the Demand Study for Alcohol Treatment Services in the NT please contact Professor James Smith, Father Frank Flynn Fellow (Harm Minimisation) on (08) 8946 8685 or via email at james.smith@menzies.edu.au