Tasmanian
Audit Office

Report of the Auditor-General
No. 11 of 2013-14

Compliance with the Alcohol, Tobacco and Other Drugs Plan 2008-13

May 2014

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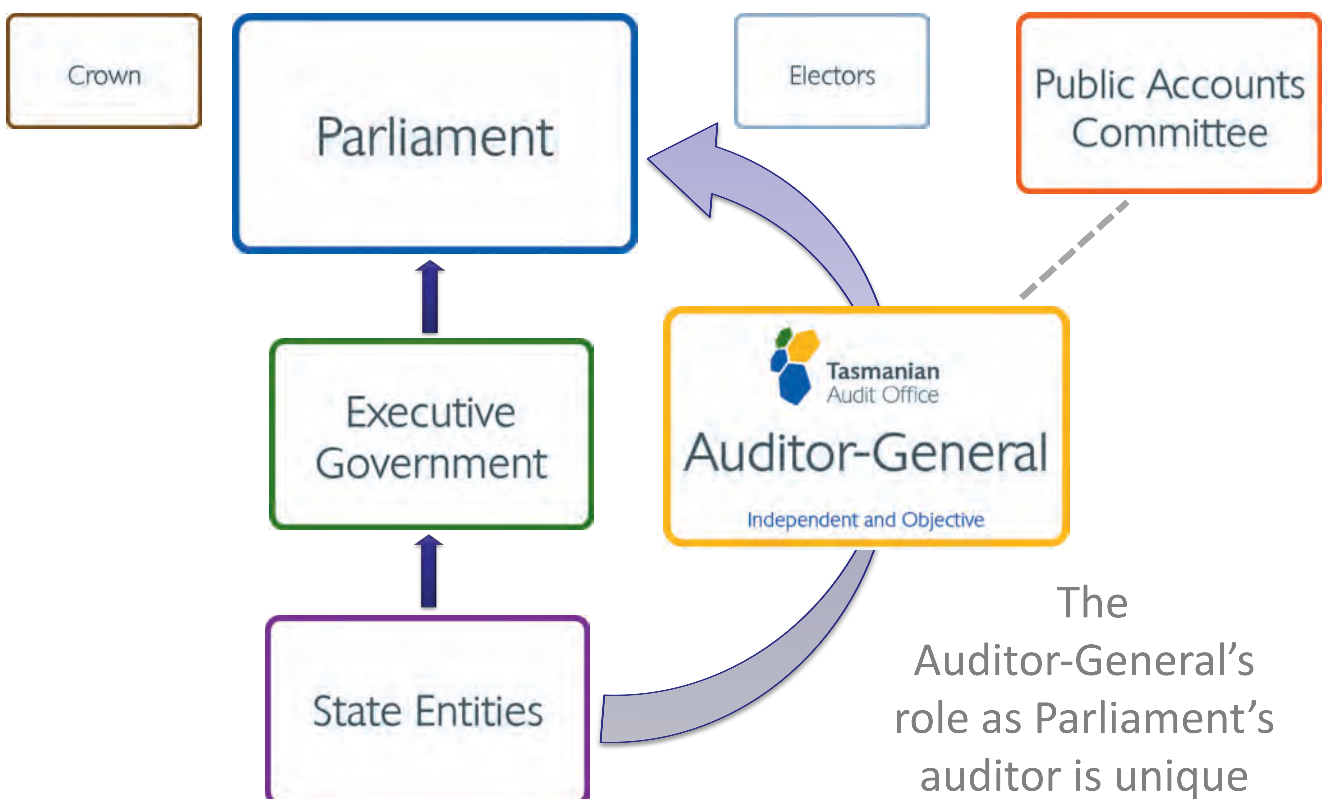

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PARLIAMENT OF TASMANIA

REPORT OF THE AUDITOR-GENERAL No. 11 of 2013–14

Compliance with the Alcohol, Tobacco and Other Drugs Plan 2008–13

May 2014

Presented to both Houses of Parliament in accordance with the provisions of the Audit Act 2008

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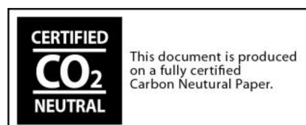

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29 May 2014

President
Legislative Council
HOBART

Speaker
House of Assembly
HOBART

Dear Mr President
Dear Madam Speaker

REPORT OF THE AUDITOR-GENERAL
No. 11 of 2013–14: Compliance with the Alcohol, Tobacco and Other Drugs Plan 2008–13

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008.* The objective of this compliance audit was to ascertain whether DHHS had implemented the strategies listed in *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13*.

Yours sincerely

E R De Santi

ACTING AUDITOR-GENERAL

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Contents

Foreword .... **vii**

List of acronyms and abbreviations .... **viii**

Executive summary **2**

1 Withdrawal management 3

2 Opioid pharmacotherapy 3

3 Psychosocial interventions and support 3

4 Strengthening organisational structures 4

Recommendations 4

Introduction **12**

1 Withdrawal management **18**

1.1 Background 18

1.2 Were state-wide guidelines in place? 19

1.3 Were common approaches to withdrawal treatment in place? 19

1.4 Had quality of (and access to) services in the IPWU improved? 20

1.5 Had access for clients from the North and North West improved? 22

1.6 Did clients have access to aftercare support? 22

1.7 Did clients have access to specialist medical services? 23

1.8 Did clients have access to specialist psychiatric support? 24

1.9 Had reliance on inappropriate services reduced? 24

1.10 Conclusion 25

2 Opioid pharmacotherapy **28**

2.1 Background 28

2.2 Had ADS implemented policy, practice standards and a shared care model of opioid pharmacotherapy? 28

2.3 Were an additional 400 clients receiving opioid pharmacotherapy treatment? 29

2.4 Were 170 additional clients dosed by ADS? 31

2.5 Did practitioners have 24/7 access to support and advice? 32

2.6 Conclusion 32

3 Psychosocial interventions and support **34**

3.1 Background 34

3.2 Youth interventions 35

3.3 Outreach services 36

3.4 Was there support for families in the North and North West? 37

3.5 Conclusion 37

4 Strengthening organisational structures ... 40
4.1 Background ... 40
4.2 Workforce development ... 40
4.3 Information management ... 42
4.4 Conclusion ... 43
Independent auditor's conclusion ... 46
Recent reports ... 50
Current projects ... 52

List of Tables

Table 1: Recommendations ... 4
Table 2: Budgeted and actual expenditure ... 14
Table 3: Audit criteria for *Priority Focus Area 2* of the ATOD Plan ... 34
Table 4: Audit criteria for *Priority Focus Area 4* of the ATOD Plan ... 40

List of Figures

Figure 1: Roles of NGO and government ATOD services ... 13
Figure 2: Average daily occupancy of the IPWU ... 21
Figure 3: Occupancy from North or North West ... 22
Figure 4: TOPP clients by provider type ... 30
Figure 5: Total clients dosed ... 31

Foreword

This Report notes:

- Drug use, including alcohol and tobacco, incurs high health and social costs for individuals and communities.
- Research supporting the National Drug Strategy shows each dollar spent on alcohol and drug treatment could save the community up to seven dollars, mostly through reductions in crime and foregone medical care[1].
- As part of the 2008–09 budget, Government committed $17.2m over four years to develop and implement *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13*. The fifth year of the Plan was not funded.
- The Plan aimed to improve service delivery by developing frameworks to facilitate services working across the Alcohol, Tobacco and Other Drug (ATOD) sector.

If the research referred to is accurate, the proposed $17.2m investment should save $120m over four years or about $30m per annum. This represents a pay-back period of less than 12 months suggesting the investment of $17.2m was a good decision.

Therefore, successful implementation of the Plan could be expected to have both social and economic benefits.

This audit set out to test the Plan's implementation and concluded that while much was done, there is still much to do. The audit noted that the Department, in consultation with the Non-Government-Sector, had, during implementation of the Plan, conducted its own analysis of progress. That analysis now needs updating by taking into account the recommendations in this Report. Doing so should assist assess value for money and design improvement.

E R De Santi

Acting Auditor-General

29 May 2014

[1] National Drug Strategy http://www.nationaldrugstrategy.gov.au

List of acronyms and abbreviations

ADIMS	*Alcohol and Drug Information Management System*
ADS	Alcohol and Drug Services
ATDC	Alcohol, Tobacco and other Drug Council of Tasmania
ATOD	Alcohol, Tobacco and Other Drugs
CAT	Clinical Assessment Tool
DHHS	Department of Health and Human Services
GPs	General Practitioners
iPM	A computer-based patient administration system
IPWU	In-Patient Withdrawal Unit
NGO	Non-Government Organisations
TOPP	*Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards 2012*
24/7	24 hours a day, seven days a week

Executive summary

Executive summary

Background

Drug use, including alcohol and tobacco, incurs high health and social costs for individuals and communities. Research supporting the National Drug Strategy shows each dollar spent on alcohol and drug treatment could save the community up to seven dollars, mostly through reductions in crime and foregone medical care[2].

In 2008, the Minister for Health launched *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13* (referred to in this Report as 'the Plan'). The Plan aimed to improve service delivery by developing frameworks to facilitate services working across the Alcohol, Tobacco and Other Drug (ATOD) sector.

As part of the 2008–09 budget, Government committed $17.2m over four years to implement the Plan. The fifth year of the Plan was not funded. Half of the $17.2m funding was earmarked for investment in the community sector.

In Tasmania, ATOD services are delivered by a range of government, community and private services. Government services are managed by Alcohol and Drug Services (ADS), a component service of Tasmanian Health Organisation — South (THO — South). At the time the Plan was developed, ADS reported directly to the Department of Health and Human Services (DHHS or 'the Department'). At the time of the audit ADS had moved under THO South.

Community services are also provided by non-government organisations (NGOs) working in the ATOD sector. These NGOs are represented by the peak body: Alcohol, Tobacco and other Drug Council of Tasmania (ATDC).

Audit objective

The objective of the audit was to ascertain whether the Department of Health and Human Services (DHHS) had implemented the strategies listed in *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13* (the Plan).

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[2] National Drug Strategy http://www.nationaldrugstrategy.gov.au

Audit conclusions

These conclusions are based on criteria we developed to support the audit's objective and are aligned to the chapter structure of this Report.

1 Withdrawal management

We found that common approaches to assessment, referral, admission, treatment and discharge planning had been developed and clients had access to specialist psychiatric support.

However we found:

- Guidelines specific to Tasmania had not been finalised.
- Specialist medical services had not been provided in the North West.
- Reliance on clinically inappropriate services in the North and North West had not reduced.
- The Department was unable to demonstrate improvement in the quality of services, although a revised approach including more rigorous admission procedures appeared reasonable.
- The revised approach had not resulted in greater access to withdrawal services.

Some of the above deficiencies had resulted from two key problems: inability to recruit and retain specialist staff and to secure sufficient aftercare support.

2 Opioid pharmacotherapy

ADS satisfied three of the five criteria we derived from the opioid pharmacotherapy outcomes listed in the Plan: development of clinical practice standards; a model of service delivery; and improved access to specialist medical support and information.

However, we found no increase in the number of clients managed or doses provided by ADS. Reasons included shortages of GPs and pharmacists prepared to work in the field, and difficulty recruiting and retaining addiction medicine specialists at ADS.

We also noted areas in which the program would benefit from improvements in information management.

3 Psychosocial interventions and support

We found ADS had increased capacity to support youth clients through the addition of five youth workers.

However, we also found little progress had been made toward:

- a Youth Services Framework to integrate alcohol and drug interventions with other government and non-government services
- a model of outreach service provision
- expanded capacity to provide support to clients who live in non-urban areas.

We also concluded there was not sufficient activity or performance data to determine the extent to which support for families in the North and North West had been delivered.

4 *Strengthening organisational structures*

We concluded ADS had achieved some successes in strengthening organisational structures as outlined in the Plan, although some outcomes remained outstanding.

There was progress toward all of the outcomes we examined under workforce development, particularly in those areas where ATDC had been involved. However, we noted difficulties recruiting and retaining staff had affected ADS's capacity to deliver workforce development services.

Regarding information management, a consistent clinical and information management system had not been implemented for all the alcohol and drug services. However, ADS had implemented changes to improve the quality of data reported to the Australian Government.

Recommendations

The Report contains the following recommendations:

Table 1: Recommendations

Rec	Section	We recommend that …
1	1.2	… ADS finalises state-wide guidelines.
2	1.4.1	… ADS works with and supports NGOs to investigate ways to measure the performance of the withdrawal management services.
3	1.4.2	… ADS works with and supports NGOs to investigate ways to increase access to withdrawal management services.

4	1.5	… ADS works with and supports NGOs to implement alternative measures to improve access for clients from the North and North West.
5	1.6	… DHHS attempts to secure funding to ensure the key stage of aftercare support does not continue to restrict achievement of planned withdrawal management outcomes.
6	1.6	… ADS works with and supports NGOs to develop alternative aftercare support services.
7	2.3	… DHHS continues to recruit addiction specialists and jointly with NGOs, investigates options to support and encourage more GPs to work with patients on the opioid pharmacotherapy program.
8	2.4	… DHHS upgrades data systems to improve information exchanged with pharmacists working with the opioid pharmacotherapy program.
9	3.2.2	… ADS works with and supports NGOs to develop a service framework to integrate alcohol and drug interventions with other government and non-government services.
10	3.3.1	… ADS works with and supports NGOs to develop a model of outreach service provision.
11	3.3.1	… DHHS investigates ways to streamline administrative processes required to implement collaborative services.
12	3.3.2	… ADS works with and supports NGOs to investigate alternative ways to expand services across all regions.
13	3.4	… ADS defines activity and performance data required for all ATOD services and perform appropriate analysis of that data.
14	4.2.4	… ADS continues to work with and support ATDC to develop and deliver workforce development programs.
15	4.3.1	… DHHS implements appropriate clinical information systems to support services across the sector.

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Audit Act 2008 section 30 — Submissions and comments received

Audit Act 2008 section 30 — Submissions and comments received

Introduction

In accordance with section 30(2) of the *Audit Act 2008*, a copy of this Report was provided to the Department of Health and Human Services.

A summary of findings, with a request for submissions or comments, was also provided to the Minister for Health and to the Treasurer.

Submissions and comments that we receive are not subject to the audit nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of these comments rests solely with those who provided the response.

Department of Health and Human Services

Thank you for the opportunity to comment on the draft report to Parliament for the compliance audit report of the Alcohol, Tobacco and Other Drugs Plan 2008-13 (the Plan). The Report has been provided to the Department of Health and Human Services (DHHS) for consideration and comment. I note that over the lifespan of the Plan DHHS organisational structure has changed and that on 1 July 2013 the Alcohol and Drug Service (ADS) became a service area within Tasmanian Health Organisation – South (THO-S).

I welcome the findings of the compliance audit which demonstrates both the achievements, and also highlights some of the challenges inherent in providing a high quality and accessible alcohol and drug service across the state, most notably the difficulty in recruiting and retaining specialist staff.

As a result of the Plan, significant progress has been made in developing the capacity and sustainability of the alcohol, tobacco and other drugs (ATOD) sector in both the government and community sector. Some of the more notable achievements include: significant investment and development in the areas of pharmacotherapy; services and supports for young Tasmanians; establishment of new service types in the areas of care coordination, advocacy, consumer participation and family support; increased support for smoking cessation; and a renewed focus on promotion, prevention and early intervention strategies.

Additionally, since the finalisation of the Plan, further progress has been made in improving services, especially in the areas of withdrawal management and opioid pharmacotherapy treatment.

The occupancy rate of the inpatient withdrawal management unit over the past seven months has been consistently higher than what was recorded over the previous five years. This has been achieved by a number of strategies including securing a more permanent medical resource to support the specialist inpatient service; improving linkages and integration with the major acute hospitals in the State; working closer with key community sector organisations; and a greater focus on flexible support options for clients following their discharge from the specialist withdrawal management facility.

The need to continue to investigate strategies to increase the capacity of the opioid pharmacotherapy treatment program is also acknowledged. A number of factors associated with opioid use necessitated that Tasmania develop a more closely supervised opioid substitution treatment program. This approach, whilst not immediately increasing the numbers of clients on the program in the shorter term, has improved the quality of treatment and significantly decreased associated risks. The Alcohol and Drug Service is now much better placed to engage and support existing and new prescribers and community pharmacies.

The compliance audit highlights a number of challenges for the ADS. One of the most significant of these is the need to attract and retain a skilled and specialist workforce, particularly in regional areas, and the lack of medical specialists in this field across Australia is a contributing factor in this regard. Workforce development will continue to be an ongoing focus and priority for ADS.

The Department of Health and Human Services and the THO-S will continue to progress the implementation of the Plan and will incorporate the compliance audit recommendations as far as is possible, noting the difficult budget and resource environment.

Matthew Daly
Secretary

Minister for Health

Thank you for the opportunity to discuss and respond to the above compliance audit.

I am pleased to accept the report and I note its recommendations.

Please convey my thanks to the Tasmanian Audit Office staff involved in the audit process

The Hon Michael Ferguson MP

Introduction

Introduction

Background

Drug use, including alcohol and tobacco, incurs high health and social costs for individuals and communities. The World Health Organisation reports treatment, including withdrawal management, does work and is cost effective[3]. Research into the effects on individuals found treatment reduced crime, decreased homelessness, increased employment and improved physical as well as mental health.

Research supporting the National Drug Strategy on the costs of alcohol and drug abuse estimates the annual costs to Australia at $55.2 billion[4]. Each dollar spent on alcohol and drug treatment could save the community seven dollars, mostly through reductions in crime and foregone medical care[5].

Government responded to the issue of alcohol and drug misuse with the *Tasmanian Drug Strategy 2005–2009*, which is consistent with the *National Drug Strategy 2004–2009*.

In 2008, the Minister for Health also launched *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13* (referred to in this Report as 'the Plan').

The Plan aimed to improve service delivery by supporting the integration of all services across the Alcohol, Tobacco and Other Drug (ATOD) sector. Based on a four-tiered model of service, the Plan provided for increasing levels of response according to client need or case complexity (see Figure 1).

[3] ATLAS on substance use (2010) — Resources for the prevention and treatment of substance use disorders http://www.who.int/substance_abuse/activities/msbaltaschthree.pdf
[4] National Drug Strategy http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf p2
[5] ADS also referred to research by the United States Department of Health and Human Services, Centre for Substance Abuse Treatment https://www.samhsa-gpra.samhsa.gov/CSAT/view/docs/SAIS_GPRA_CostOffsetSubstanceAbuse.pdf

Figure 1: Roles of NGO and government ATOD services

Tier	Tier 1 (primary services)	Tier 2 (primary and secondary services)	Tier 3 (secondary services)	Tier 4 (tertiary services)
Client group	Whole of population	Substance users	Established substance abuse	Chronic substance abuse
Substance use behaviour	All Tasmanians	Experimental or regular	Substance dependence	Stabilisation and recovery
Service sectors	Mainstream Health and Human Services, Population Health, Primary Health, GPs, information services	Mainstream Health and Human Services, Population Health, Primary Health, GPs and NGOs	Specialist (non-medical) alcohol and drug services in both government and NGOs	Specialist treatment and extended care services provided predominantly by government
Interventions	• Media campaigns • Tobacco control • Legislative controls • Mainstream health services e.g. GPs, community health	• Programs • Health information and referrrals • Advice e.g. GPs, community nurses • Support groups • Quit programs	• Counselling • Early interventions • Outreach • Youth services • Places of safety • Group work • Relapse prevention • Accommodation	• Pharmacotherapy • Withdrawal management • Residential rehabilitation • Consultation and liaison services

Source: Tasmanian Audit Office derived from ADS data

In Tasmania, specialist ATOD services are delivered by a range of public, community and private services. Public services are managed by Alcohol and Drug Services (ADS), a component service of Tasmanian Health Organisation — South (THO — South) – Mental Health and State-wide Services. At the time the Plan was developed, ADS reported directly to the Department of Health and Human Services (DHHS or 'the Department'). At the time of the audit ADS had moved under THO South. Community services provided by non-government organisations (NGOs) are represented by the peak body: Alcohol, Tobacco and other Drug Council of Tasmania (ATDC). Specialist ATOD services provide:

- treatment and intervention (to clients)
- education and support (to other health and community services).

The Plan identified four 'Priority Focus Areas', namely:

- treatment and ongoing care services
- psychosocial interventions and support services
- health promotion, demand management and harm reduction
- strengthening organisational structures.

The Plan further divided each Priority Focus Area. For instance, 'Treatment and Ongoing Care Services' contained the separate elements of withdrawal management, opioid pharmacotherapy, consultation liaison and residential rehabilitation. All up, the Plan encompassed 75 initiatives, with timeframes that vary throughout the five-year period.

The *DHHS 2009–10 Annual Report* applied four key performance indicators to ADS:

- alcohol and drug services — closed episodes of treatment
- pharmacotherapy program — total active participants
- withdrawal unit — bed occupancy
- withdrawal unit — average length of stay.

As part of the 2008–09 budget, the Government committed $17.2m over four years to implement the Plan. The fifth year of the Plan was not funded. Half the funding was earmarked for investment in the community sector. Table 2 shows budgeted and actual expenditure for each of the four years of the Plan.

Table 2: Budgeted and actual expenditure

	Budget ($m)	Actual expenditure ($m)
2008-09	1.8	0.7
2009-10	3.8	3.4
2010-11	5.4	5.3
2011-12	6.2	6.5
Total	17.2	15.9

Source: Tasmanian Audit Office derived from ADS data

Table 2 shows that not all of the budgeted funds were spent ($1.34m or 7.8 per cent underspend), with most of the underspend occurring in the first year.

Audit objective

The objective of the audit was to ascertain whether DHHS had implemented the strategies listed in *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan, *2008/09 – 2012/13* (the Plan).

Audit scope

The scope of the audit encompassed progress made by the Department on the Plan, from inception of the Plan in 2008–2009 until the time the audit commenced.

Audit criteria

Using a judgement selection, we applied the following audit criteria, derived from initiatives and outcomes listed in the Plan:

- Have withdrawal management elements of the Plan been delivered? (Chapter 1)
- Have opioid pharmacotherapy elements of the Plan been delivered? (Chapter 2)
- Have psychosocial interventions listed in the Plan been delivered (Chapter 3), namely:
  - youth interventions
  - outreach services outside major city centres
  - support for families?
- Have organisational structures listed in the Plan been strengthened (Chapter 4), namely:
  - workforce development
  - information management?

Audit approach

To conduct the audit, we examined documentation and interviewed relevant staff at DHHS.

Timing

Planning for this audit was completed in May 2013 and fieldwork was completed in March 2014. Reporting was finalised in May 2014.

Resources

The audit plan recommended 675 hours and a budget, excluding production costs, of $96 697. The audit met those projections, taking a total of 658 hours and $98 308 actual costs, excluding production.

Why this project was selected

Our *Annual Plan of Work 2012–13* listed 'various smaller compliance projects'. This audit was developed because the subject area is a matter of considerable public interest and demand for services continues to increase.

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1 Withdrawal management

1 Withdrawal management

1.1 Background

The Plan described withdrawal management services under Priority Focus Area 1*: Treatment and ongoing care services.*

Treatment is varied and can include:

- opioid pharmacotherapy
- relapse prevention
- rehabilitation
- consultation and liaison.

Services are required in different settings such as residential rehabilitation, outpatient clinics and correctional settings.

ADS initiated a significant change to withdrawal management services by opening a dedicated ten-bed Inpatient Withdrawal Unit (IPWU) late in 2006, prior to announcement and funding of the Plan. Work completed under the Plan included developing new admission and discharge processes for the IPWU.

ADS reported difficulties recruiting medical specialists which had affected several Plan outcomes, such as access to services state-wide (discussed further in Section 1.7 of this Chapter).

The first set of audit criteria examined whether the withdrawal management element of the Plan had been delivered. We derived nine criteria from outcomes listed in the Plan, namely:

- Were state-wide guidelines in place?
- Had common approaches to assessment, referral, admission, treatment and discharge planning been developed?
- Had the quality of withdrawal management service in the South improved?
- Had access to the 10-bed withdrawal management service in the South improved?
- Was there access to withdrawal management services for up to six clients from the North and/or North West at any one time?
- Was aftercare support following withdrawal available when required?
- Were specialist medical services available in all three regions?
- Was specialist psychiatric support for withdrawal management available to clients?

- Was there evidence of reduced reliance on inappropriate services for withdrawal management in the North and North West?

Our findings in relation to these criteria are given in the following sections of this Chapter.

1.2 Were state-wide guidelines in place?

The Plan listed a need to develop and implement guidelines for withdrawal management in Tasmania. Outcomes included state-wide guidelines based on best practice and developed in conjunction with Acute Care Services[6].

During fieldwork, we found guidelines for the provision of withdrawal management in Tasmania existed in draft form. As an interim measure, ADS had adopted the guidelines in place in New South Wales which ADS considered as contemporary and best practice.

Recommendation 1
We recommend that ADS finalises state-wide guidelines.

1.3 Were common approaches to withdrawal treatment in place?

The common approaches listed in the Plan aimed to cover processes for assessment, referral, admission, treatment and discharge planning for withdrawal treatment. As such, these common approaches applied to services provided in different settings, such as:

- ADS, other government services such as Acute Care Services (hospitals)
- justice (detention centres)
- general practitioners (GPs)
- pharmacists
- NGOs involved in the ATOD sector.

To implement a common approach, ADS developed a Clinical Assessment Tool (CAT) to be used by all ADS clinicians to help identify appropriate treatment programs for each client.

[6] Acute Care Services are active generally short-term treatments for patients suffering severe injuries or episodes of illness. Acute Care Services are typically provided in hospitals including emergency departments, intensive care units and neo-natal facilities. In these settings patients are usually receiving treatment for other injuries or illnesses which may be complicated by alcohol and drug issues.

Another aspect of the common approach was a standard referral form developed at IPWU for use by other alcohol and drug services including external service providers.

These new processes included developing a *Negotiated Care Plan* with each client. These were used to aid discharge planning by ensuring clients were appropriately supported following their discharge from the IPWU.

We were satisfied ADS had developed common approaches to assessment, referral, admission, treatment and discharge planning.

1.4 Had quality of (and access to) services in the IPWU improved?

For this attribute, the Plan listed improved quality of service and access to the dedicated ten-bed withdrawal service in the South.

1.4.1 Had quality of services in the IPWU improved?

In 2006, ADS opened the dedicated ten-bed IPWU at St John's Park, about six kilometres from Hobart's CBD. Prior to that, withdrawal services were based at an inner city facility that operated with less rigorous admission procedures. Some clients chose to stay only a night or two which limited their treatment.

Under the Plan, more rigorous case management was implemented to improve the quality of withdrawal services. The new processes focused on providing specialist services in preparation for longer-term treatments. Typically, clients enter the IPWU for five to seven days in preparation for referral to residential rehabilitation (provided by NGOs) or counselling and other support services. Under the new approach, clients are not generally admitted to the IPWU without arrangements in place to ensure access to post-discharge support services.

Services at the new facility are delivered in line with the guidelines supporting the National Drug Strategy[7]. We found the new approach intuitively sensible, with ADS providing critical services in preparation for longer-term treatments.

However, no data was available to measure the quality of withdrawal management services. We consider such a measure was necessary to validate the current arrangements.

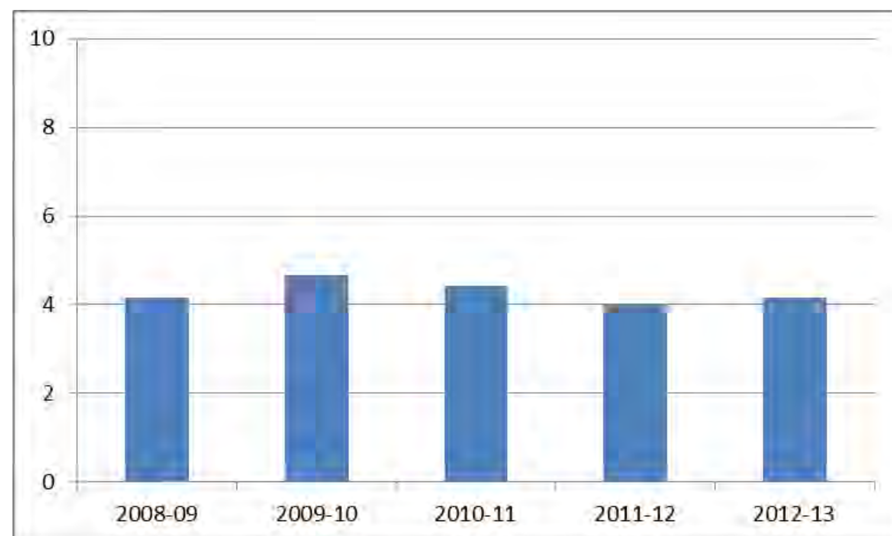
[7] National Drug Strategy http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64-l~mono64-l-exec-summary

Recommendation 2
We recommend that ADS works with and supports NGOs to investigate ways to measure the performance of the withdrawal management services.

1.4.2 Had access to services in the IPWU improved?

Attributes listed in the Plan included improved access to the ten-bed withdrawal management service in the South. The average number of beds occupied in the IPWU each day is shown in Figure 2.

Figure 2: Average daily occupancy of the IPWU



Source: Tasmanian Audit Office derived from ADS data

Occupancy rates consistently averaged less than 50 per cent, with no significant change over the five years of the Plan. To put that low occupancy in context, national models used by the Department to estimate demand for inpatient withdrawal services suggested a population the size of Tasmania was likely to be as high as17 beds.

ADS advised factors affecting the occupancy rate, and therefore access to services, included:

- difficulty recruiting and retaining medical specialists (at best, ADS has had two specialists working at the IPWU)
- lack of availability of post-discharge services (such as residential rehabilitation services), as required by the new admission procedures. This is further discussed in Section 1.6.

We concluded that access to the service had not improved.

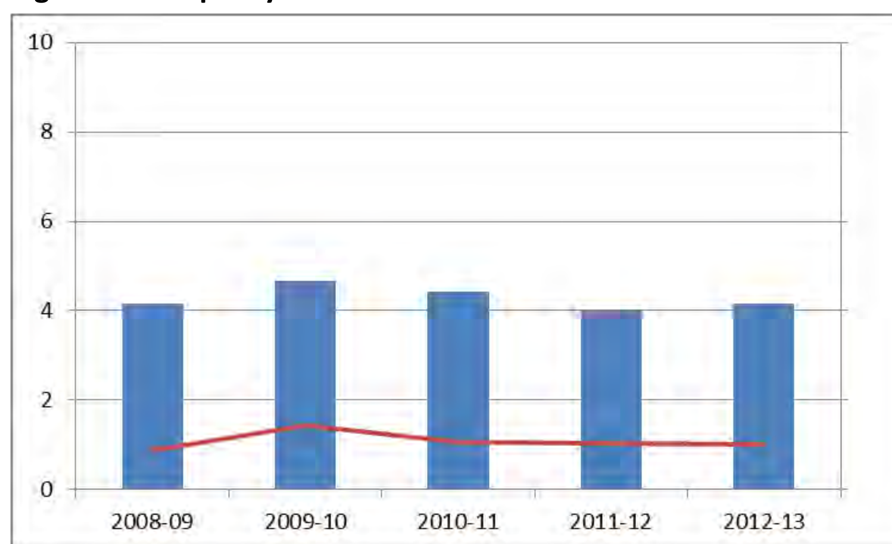
Recommendation 3

We recommend ADS works with and supports NGOs to investigate ways to increase access to withdrawal management services.

1.5 Had access for clients from the North and North West improved?

A specific outcome in the Plan was access to withdrawal management services for up to six clients from the North and or North West at any one time. Admissions from the North and North West are shown by the red line in Figure 3.

Figure 3: Occupancy from North or North West



Source: Tasmanian Audit Office derived from ADS data

Whilst actual use averaged approximately one bed, there were clearly available beds in the IPWU to meet the planned outcome. On the other hand, as discussed in Section 1.4.2, there was insufficient capacity to staff those beds and lack of availability of post-discharge services.

In summary, the low occupancy rates of the IPWU suggested access to withdrawal services had not improved for any clients, including those from the North and North West.

Recommendation 4

We recommend ADS works with and supports NGOs to implement alternative measures to improve access for clients from the North and North West.

1.6 Did clients have access to aftercare support?

Withdrawal management also required access to aftercare support for clients following withdrawal, when required.

As discussed in Section 1.4, arrangements for aftercare support are a prerequisite for admission to withdrawal management services available in the new IPWU. Aftercare support included access to residential rehabilitation where required.

Three NGOs provided residential rehabilitation, some in the North and some in the South. ADS reported access to residential rehabilitation in Tasmania was challenging and continued to need significant investment. Each of the NGO programs were operating at capacity and had waiting lists for their services. Funding delivered under the Plan had enabled NGOs to keep existing beds open. However, the investment had not been enough to implement initiatives listed for the fifth year of the Plan, which included increasing the capacity of residential rehabilitation services.

ADS stated work had been undertaken, in collaboration with other government and non-government services, to improve referral processes and therefore outcomes for clients. However, no records were available to substantiate whether the collaborative work had increased services or improved outcomes for clients.

We were not satisfied work completed under the Plan had increased aftercare support for clients following withdrawal.

Recommendation 5

We recommend DHHS attempt to secure funding to ensure the key stage of aftercare support does not continue to restrict achievement of planned withdrawal management outcomes.

Recommendation 6

We recommend ADS works with and supports NGOs to develop alternative aftercare support services.

1.7 *Did clients have access to specialist medical services?*

Targets listed in the Plan included specialist medical services in all three regions of the state. As mentioned previously, ADS experienced difficulties recruiting addiction specialists to work in the state. The few specialists who had tried relocating to Tasmania reported the regional nature of the State did not suit other members of their families.

A world-wide shortage of medical practitioners specialising in addiction medicine contributed to the difficulties recruiting addiction specialists. The shortage, and a reluctance to resettle

in regional areas, meant it was very difficult to recruit specialists to work in rural areas.

As an alternative to services based in the North West, practitioners based in the North provide medical support to clients in the North West through phone, email and video-conferencing. Practitioners from the North also visit some clients in the North West.

In summary, the target listed in the Plan — to provide specialist medical services across the State — did not appear unreasonable. However, efforts to base services in the North West showed that part of the target was not feasible. We were satisfied that the specialist medical services provided to the North West through services based in the North was a sensible and realistic alternative.

1.8 Did clients have access to specialist psychiatric support?

Another aspect of withdrawal management covered in the Plan was access to specialist psychiatric support.

ADS employed a psychiatrist whose speciality was addiction medicine. Access to specialist psychiatric was available through Mental Health Services. ADS clinicians provided clients with referrals to specialists when required and helped facilitate that process.

We were satisfied that IPWU clients had access to specialist psychiatric support, either via Mental Health Services or by utilising an ADS-employed specialist.

1.9 Had reliance on inappropriate services reduced?

The Plan also included reducing reliance on services for withdrawal management in the North and North West that were regarded as clinically inappropriate.

ADS advised it had tried several strategies to improve IPWU access for North and North West clients. The IPWU Nurse Unit Manager visited the region in an attempt to identify issues preventing services from referring clients. ADS increased marketing of the IPWU by discussing services with GPs and other service providers in the region. Pamphlets and electronic resources were also distributed across the region to advertise access to the unit.

Despite these efforts to improve access for clients in the North and North West, strategies still needed to be revisited. ADS agreed that further work needed to be done in this area.

1.10 Conclusion

We found that common approaches to assessment, referral, admission, treatment and discharge planning had been developed and clients had access to specialist psychiatric support.

However we found:

- Guidelines specific to Tasmania had not been finalised.
- Specialist medical services had not been provided in the North West.
- Reliance on clinically inappropriate services in the North and North West had not reduced.
- The Department was unable to demonstrate improvement in the quality of services, although a revised approach including more rigorous admission procedures appeared reasonable.
- The revised approach had not resulted in greater access to withdrawal services.

Some of the above deficiencies had resulted from two key problems: inability to recruit and retain specialist staff and to secure sufficient aftercare support.

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2 Opioid pharmacotherapy

2 Opioid pharmacotherapy

2.1 Background

Through regular doses of legal drugs, opioid pharmacotherapy treatment enables opioid users to reduce or stop illegal, harmful and dangerous drug use.

In Tasmania, pharmacotherapy programs are managed by general practitioners (GPs) and ADS doctors. Dosing mainly occurs in pharmacies, although a small number of clients were managed through the southern pharmacotherapy unit at the ADS.

The Plan lists opioid pharmacotherapy in Priority Focus Area 1: *Treatment and ongoing care services*. The second set of audit criteria examined whether the opioid pharmacotherapy elements of the Plan had been delivered. We derived audit criteria from outcomes listed in the Plan relating to opioid pharmacotherapy:

- Had ADS implemented opioid pharmacotherapy policy and clinical practice standards?
- Had ADS developed an evidence-based, shared care model of opioid pharmacotherapy treatment?
- Were an additional 400 clients receiving opioid pharmacotherapy treatment?
- Had an additional 170 clients been dosed by government services?
- Did Acute Care Services, GPs and pharmacists have access to specialist medical support, advice and information 24/7[8]?

Our findings in relation to these five criteria are given in the following sections of this Chapter.

2.2 Had ADS implemented policy, practice standards and a shared care model of opioid pharmacotherapy?

The Plan listed initiatives to improve opioid pharmacotherapy, including implementing policy and clinical practice standards for Tasmania.

[8] Acute Care Services are active generally short-term treatments for patients suffering severe injuries or episodes of illness. Acute Care Services are typically provided in hospitals including emergency departments, intensive care units and neo-natal facilities. In these settings patients are usually receiving treatment for other injuries or illnesses which may be complicated by alcohol and drug issues.

We found that the Department had developed a clinical standard: the *Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards 2012* (TOPP).

The Department had also developed a shared care model of service delivery to outline how TOPP was to be applied in practice[9]. The shared-care aspect related to ADS medical specialists and approved GPs working in the community. The model was based on research and studies underpinning the National Drug Strategy (2010–15).

We were satisfied ADS had delivered the outcome of developing an evidence-based, shared care model of treatment that reflected contemporary best practice.

2.3 Were an additional 400 clients receiving opioid pharmacotherapy treatment?

Initiatives listed in the Plan included increasing the number of clients on the opioid pharmacotherapy program, as an outcome to treat an additional 400 clients.

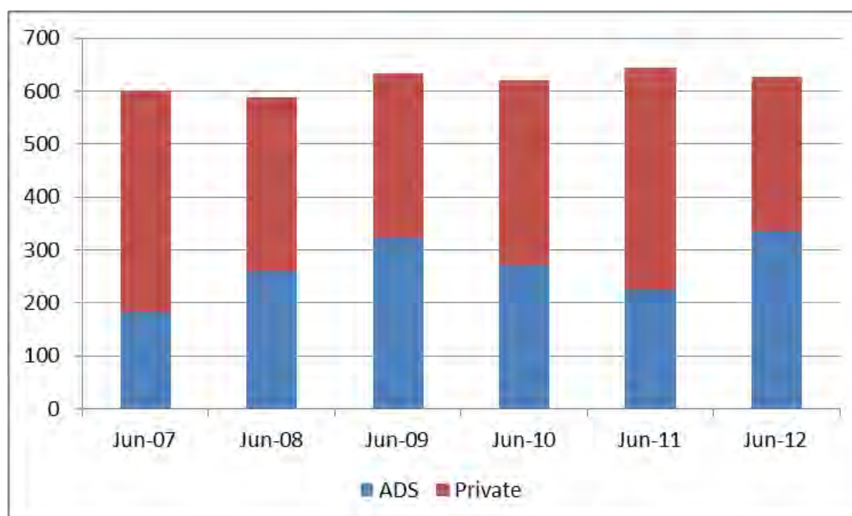
To enter the opioid pharmacotherapy program, clients are first assessed and prescribed by ADS. High-risk clients and those with complex needs, remain with ADS while low-risk clients may progress to being managed by a GP in the community. Typically, ADS sees high-risk clients daily whereas those at low risk may only need to see their GP monthly. The number of clients ADS can manage is limited when clients are unable to move on to treatment with a private GP.

ADS was required to report the number of TOPP clients by prescriber type to the Commonwealth[10]. Figure 4 shows the number of clients prescribed by either ADS or private (community based) GPs.

[9] Model of Service Delivery for Opioid Pharmacotherapy (May 2013)

[10] The Australian Institute of Health and Welfare's National Opioid Pharmacotherapy Statistics Annual Data is a set of jurisdictional data for a snapshot day in the month of June.

Figure 4: TOPP clients by provider type



Source: Tasmanian Audit Office derived from ADS data

The comparison of the June 2007 client numbers with the years of the Plan shows no significant change in the total number of clients on the program. ADS advised that 628 new clients had accessed the opioid pharmacotherapy program since the Plan began in 2008. However, the total number had not increased significantly. Clients left the program for a variety of reasons including moving interstate or abandoning their programs.

The Department advised that a limitation on its capacity to increase the number of clients had been the number of GPs in the community prepared to work in the field of addiction medicine, particularly in remote areas. For instance, in 2009 and 2012 a significant percentage of private GPs retired or left the program, which led to ADS having to absorb those clients.

A further restriction had been difficulty in recruiting and retaining addiction medicine specialists at ADS.

The Department was unable to provide information on the number of people presenting for treatment who were unable to access the program. Anecdotal evidence from ATDC was that considerable unmet demand existed.

Accordingly, we conclude that the outcome had not been achieved and that the number of clients on the program had not increased by 400 during the five years of the Plan.

Recommendation 7

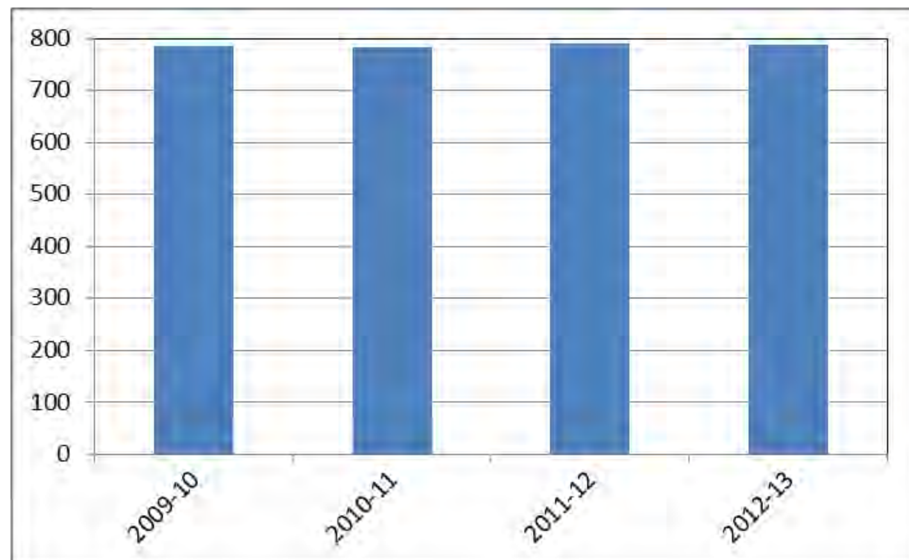
We recommend DHHS continues to recruit addiction specialists and jointly with NGOs, investigate options to support and encourage more GPs to work with patients on the opioid pharmacotherapy program.

2.4 Were 170 additional clients dosed by ADS?

Outcomes listed in the Plan included an additional 170 clients dosed by government-provided services, rather than by private pharmacists.

The Department was unable to provide separate data of the number of clients receiving doses directly from ADS. Instead, we looked at the total number of clients dosed (ADS and private pharmacists combined) to see if a significant increase had occurred (see Figure 5).

Figure 5: Total clients dosed



Source: Tasmanian Audit Office derived from ADS data. Data was not available for the first year of the Plan, 2008–09.

The chart shows no significant increase over the last four years of the Plan. In our view that makes it likely that there has been no substantial change in the total number of clients dosed by ADS.

A factor limiting the number of clients dosed was a shortage of outlets for delivering doses. That, in turn, was dependent on the number of pharmacists prepared to join the opioid pharmacotherapy program.

At the time of the audit, pharmacists working with the opioid pharmacotherapy program still used manual information systems. Substantial delays existed between clients being dosed

and ADS receiving updated data. Similarly, pharmacists were not able to access clients' information without delays.

ADS advised that 166 new clients had been dosed by ADS since 2009–10. However, the total number of clients dosed did not increase by more than seven.

Accordingly, we conclude that the total number of clients dosed by government-provided services had not increased by an additional 170 clients.

Recommendation 8

We recommend DHHS upgrade data systems to improve information exchanged with pharmacists working with the opioid pharmacotherapy program.

2.5 *Did practitioners have 24/7 access to support and advice?*

Outcomes listed in the Plan included 24/7 access to specialist advice and support for acute care services, GPs and pharmacists.

ADS advised consultation and liaison services are available in the Royal Hobart Hospital. These services are provided by a specialist nurse and a visiting medical specialist, by appointment.

Prior to the Plan, this support was usually limited to ordinary business hours. Funding under the Plan enabled ADS to provide on-call support by a medical specialist, 24/7. This service could also be utilised by other health providers.

Medical and clinical staff also had 24/7 telephone access to support through the Drug and Alcohol Clinical Advisory Service contracted through Turning Point in Victoria.

We concluded that the level of specialist advice and support available to acute care services, GPs and pharmacists had increased in line with the outcome in the Plan.

2.6 *Conclusion*

ADS satisfied three of the five criteria we derived from the opioid pharmacotherapy outcomes listed in the Plan: development of clinical practice standards; a model of service delivery; and improved access to specialist advice and support.

However, we found no increase in the number of clients managed or doses provided by ADS. Reasons included shortages of GPs and pharmacists prepared to work in the field, and difficulty recruiting and retaining addiction specialists at ADS.

We also noted areas in which the program would benefit from improvements in information management.

3 Psychosocial interventions and support

3 Psychosocial interventions and support

3.1 Background

The Plan lists psychosocial interventions and support services under Priority Focus Area 2. Psychosocial interventions and support services describe a wide variety of services, supports and strategies that aim to change behaviour and support people with drug and alcohol problems. Non-medical services, often delivered in a community setting, were:

- counselling
- case management
- coordination of care
- group work
- community education
- professional consultation to other service providers.

We derived audit criteria from outcomes listed under the three areas of Psychosocial Interventions and Support that we selected for audit. The criteria are listed in Table 3.

Table 3: Audit criteria for *Priority Focus Area 2* of the ATOD Plan

ATOD section	Audit criteria
Youth interventions	An increase in the number of specialist alcohol and drug youth workers
	Consultation support and services for children and family services
Outreach	A model of Outreach service provision for Tasmania had been developed
	Support for clients in non-urban centres had increased
Support for families	Support for families in the North and North West including information sessions for 200 to 250 clients per year
	15 family support programs per year across the North and North West for 100 to 125 clients

3.2 Youth interventions

Up to 50 per cent of youth justice clients have problems stemming from alcohol or drugs. The following two sections review related strategies.

3.2.1 Was there an increase in the number of specialist alcohol and drug youth workers?

The Plan included initiatives aimed at increasing the number of specialist alcohol and drug youth workers to provide information, support, advice and referral for young people. The stated outcome was to support an additional 80 clients.

Five new specialist youth workers had been appointed under the Plan, two with ADS and three within relevant NGOs. Each of the new positions has capacity to provide information, support, advice and referrals services to at least 20 young people.

Based on this information, we were satisfied that sufficient specialist alcohol and drug youth workers had been recruited to support an additional 80 clients.

3.2.2 Had ADS increased support for children and family services?

The Plan aimed to better support relevant workers in the range of children and family services, when alcohol and other drug issues were encountered. It included development of a framework to integrate alcohol and drug interventions with other government and non-government services.

We found that the increased number of ATOD youth workers (see Section 3.2.1), had increased the capacity of ADS to support children and family services. In addition, an NGO family support service in the North West had been created. The focus of that service was working with families that had complex alcohol and drug issues (see Section 3.4).

However, development of a Youth Services Framework had not been completed.

We concluded that ADS had increased support to children and family services; however, the planned initiatives had not been fully implemented.

Recommendation 9

We recommend ADS works with NGOs to develop a service framework to integrate alcohol and drug interventions with other government and non-government services.

3.3 Outreach services

As well as clients, outreach services may support other health and community services, enabling them to better manage clients who present with alcohol, tobacco and other drug problems. Outreach services include counselling, assisting development of harm-reduction strategies and providing access to specialist advice.

3.3.1 Had a model of outreach service provision been developed?

The Plan included development of a model of outreach service provision.

We found that ADS had not developed a model of outreach service provision. An outreach service working with existing NGO and other services had been initiated on the East Coast that could have provided a basis for development of a model.

However, the service could not retain specialists recruited to work on the East Coast. Reasons included family relocation difficulties and delays in the implementation of collaborative services. ATDC cited departmental bureaucracy as a reason for the delays and argued for streamlining of administrative processes.

In conclusion, we were not satisfied a model of outreach service provision had been developed for Tasmania.

Recommendation 10

We recommend ADS works with and supports NGOs to develop a model of outreach service provision.

Recommendation 11

We recommend DHHS investigates ways to streamline administrative processes required to implement collaborative services.

3.3.2 Had ADS increased support for clients in non-urban settings?

The second Plan initiative that we examined under outreach services was increasing services to clients who live outside major city centres.

As discussed in Section 3.3.1, we found ADS had initiated a service on the East Coast that aimed to work with other services already established in the area. However, difficulty retaining staff and long implementation delays had led to that service being largely abandoned and not expanded to other areas.

ADS reported expansion of the service was dependent on funding and it had earmarked this outcome for future development.

We were not satisfied that the capacity to provide support to clients who live outside major city centres had increased as envisaged in the Plan.

Recommendation 12

We recommend ADS works with and supports NGOs to investigate alternative ways to expand services across all regions

3.4 Was there support for families in the North and North West?

In line with Plan outcomes, we considered whether:

- support for families in the North and North West of the State had increased, including the provision of information sessions for between 200 and 250 clients per year
- 15 family support programs per year had been provided across the North and North West to support between 100 and 125 clients.

We found records that the Plan had provided access to funding for specialist support services for families experiencing complex alcohol and drug issues in the North and North West. However, recruitment issues had also impacted these services, delaying commencement until late 2012.

ADS reported an NGO had begun delivering information sessions and support services to families in the North West, but had not developed a reporting system.

Without activity or performance data we could not determine the extent to which the outcomes had been delivered.

Recommendation 13

We recommend ADS defines activity and performance data required for all ATOD services and perform appropriate analysis of that data.

3.5 Conclusion

Of the criteria relating to psychosocial interventions we derived from the Plan, we found ADS had increased capacity to support youth clients through the addition of five youth workers.

However, we also found little progress had been made toward:

- a Youth Services Framework to integrate alcohol and drug interventions with other government and non-government services
- a model of outreach service provision
- expanded capacity to provide support to clients who live in non-urban areas

We also concluded there was not sufficient activity or performance data to determine the extent to which support for families in the North and North West had been delivered.

4 Strengthening organisational structures

4 Strengthening organisational structures

4.1 Background

We derived audit criteria from outcomes listed under Priority Focus Area 4 of the Plan, namely 'Strengthening organisational structures'. Of the various initiatives that were described, we chose two for examination, together with their respective outcomes (see Table 4)

Table 4: Audit criteria for *Priority Focus Area 4* of the ATOD Plan

ATOD section	Audit criteria
Workforce development	A dedicated Workforce Development Unit
	A professional development program
	Entry level qualifications and competencies
	Medical registrar and graduate nursing program.
Information management	Consistent clinical and information management system for all alcohol and drug services
	Improved the quality of information reported nationally

4.2 Workforce development

The Plan indicated Tasmania had the lowest number of alcohol and drug counsellors and clinical psychologists per head of population of all Australian jurisdictions[11]. Clearly, there was a need for workforce development.

Difficulties recruiting and retaining addiction specialist staff had impacted many aspects of the Plan, as already discussed in Chapters 2 and 3. ADS reported the shortage of medical staff trained or willing to work in addiction medicine was a global phenomenon. ADS had engaged a specialist recruitment agency in an effort to seek addiction specialists nationally and internationally. During the five years of the Plan, the few specialists that started working in the State have left citing problems resettling their families.

[11] In 2001, Tasmania had the lowest number of alcohol and drug counsellors (66 per cent below the national average) and clinical psychologists (33 per cent below the national average) per 100,000 population of all states. The Plan p.32.

4.2.1 Had a workforce development unit been developed?

We found ADS had established a Workforce Development Unit for the sector comprising two positions: one focusing on addiction nursing, the other on allied health services.

However, difficulties retaining staff in the Workforce Development positions had delayed implementation of some of the strategies.

To support development within the non-government sector, ADS also provided funding to the peak body for NGOs, namely the ATDC. With that funding, ATDC implemented a range of workforce initiatives including:

- a training needs analysis for the community sector
- coordination and delivery of ATOD training.

4.2.2 Were professional development programs and entry level qualifications set?

ADS and ATDC had identified core and mandatory training requirements for the ATOD workforce; entry level qualifications and competencies had been set for all staff.

ATDC had developed a training program to increase the skills of workers within the ATOD sector. Plans had been approved and funding had been secured to deliver that training over the next two years.

4.2.3 Was there a medical registrar and graduate nursing program?

ADS had established both medical registrar and graduate nursing programs as specified in the Plan. Funding for an additional specialist training program had also been secured.

4.2.4 Conclusion — workforce development

Progress had been made toward all of the outcomes we examined under workforce development, particularly in the areas where ATDC was involved. However, we noted difficulties recruiting and retaining staff also affected ADS's capacity to deliver these services.

Recommendation 14

We recommend ADS continues to work with and support ATDC to develop and deliver workforce development programs.

4.3 Information management

4.3.1 Had a clinical and information management system been developed?

We found there was little or no data available to measure performance against many of the Plan outcomes. For example, no data was available to show whether changes to the withdrawal management system had increased benefits to clients (see Section 1.4). Likewise, data collected on the opioid pharmacotherapy program could not separate doses delivered by government and community-based pharmacists (see Section 2.4).

We also found that a clinical information management system had not been developed and that paper records continued to be used. A significant consequence was that pharmacists could not electronically access up-to-date client information at the point and time of delivery.

A department-wide patient administration system (iPM) had been implemented in 2012, but this did not include clinical information and did not meet the envisaged outcome of the Plan.

Recommendation 15

We recommend DHHS implements appropriate clinical information systems to support services across the sector.

4.3.2 Had the quality of national data reporting improved?

The Plan also recognised a need to improve the quality of information reported nationally.

Prior to the implementation of iPM, ADS used the *Alcohol and Drug Information Management System* (ADIMS) to record ATOD information. However, ADIMS could not adapt to evolving reporting requirements and became unreliable. NGOs had developed their own reports using various spread sheets.

We found that to improve the quality of information reported nationally ADS had:

- provided NGOs with a consistent spread sheet to capture data
- used iPM to capture and report the required data
- complied with new validation requirements for the national data.

We conclude that ADS has implemented changes to improve the quality of information reported nationally.

4.4 Conclusion

We concluded ADS had achieved some successes in strengthening organisational structures as outlined in the Plan, although some outcomes remained outstanding.

There was progress toward all of the outcomes we examined under workforce development, particularly in those areas where ATDC had been involved. However, we noted difficulties recruiting and retaining staff affected ADS's capacity to deliver workforce development services.

Regarding information management, a consistent clinical and information management system had not been implemented for all the alcohol and drug services. However, ADS had implemented changes to improve the quality of data reported to the Commonwealth.

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Independent auditor's conclusion

Independent auditor's conclusion

This independent conclusion is addressed to the President of the Legislative Council and to the Speaker of the House of Assembly. It relates to my compliance audit of aspects of the implementation of a plan aimed at better managing our State's alcohol, tobacco and other drug services.

Audit objectives

The objectives of the audit were to assess whether the Department of Health and Human Services (the Department) had implemented the strategies listed in *Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions* – a five year plan*, 2008/09 – 2012/13* (the Plan).

Audit scope

The scope of the audit encompassed progress made by the Department on the Plan, from its inception in 2008–2009 until the time the audit commenced. The audit looked at services described in the $17.2m Plan, excluding additional work done to assist Tasmanians to quit smoking.

Responsibility of the Secretary of the Department of Health and Human Services

The Secretary is responsible for developing processes to ensure the Plan is implemented in accordance with its requirements.

Auditor-General's responsibility

In the context of this compliance audit, my responsibility was to carry out audit procedures to enable me to express a conclusion on whether the processes implemented resulted in compliance with the Plan.

I conducted my audit in accordance with Australian Auditing Standard ASAE 3100 *Compliance engagements*, which required me to comply with relevant ethical requirements relating to audit engagements. I planned and performed the audit to obtain reasonable assurance whether the Department had implemented the strategies listed in the Plan.

Using a judgement selection, I applied the following audit criteria, derived from initiatives and outcomes listed in the Plan:

- Have withdrawal management elements been delivered?
- Have opioid pharmacotherapy elements been delivered?

- Have psychosocial interventions listed been delivered, namely:
  - youth interventions
  - outreach services outside major city centres
  - support for families?
- Have organisational structures listed been strengthened, namely:
  - workforce development
  - information management?

To conduct the audit, I examined documentation and interviewed relevant Departmental staff.

I believe that the evidence I have obtained was sufficient and appropriate to provide a basis for my conclusion.

Auditor-General's conclusion

Based on the audit objective, scope and criteria and for the reasons outlined in this Report, it is my overall conclusion that, to a large extent, the Department had implemented the various steps called for in the Plan. However, implementation had not always resulted in improvements to alcohol, tobacco and other drug services. Reasons for this are outlined in this Report.

As a result, my report contains fifteen recommendations which were aimed at:

- improving access to services and developing alternative aftercare services
- investigating options to support and encourage more GPs to work with patients in the opioid pharmacotherapy program
- improving data and data systems
- streamlining administration and
- defining activity and performance data and analysing such data.

E R De Santi

Acting Auditor-General

29 May 2014

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Recent reports

Recent reports

Tabled	No.	Title
Nov	No. 5 of 2012–13	Volume 1 — Analysis of the Treasurer's Annual Financial Report 2011–12
Nov	No. 6 of 2012–13	Volume 2 — Executive and Legislature, Government Departments, other General Government Sector State entities, other State entities and Superannuation Funds 2011–12
Dec	No. 7 of 2012–13	Compliance with the *Tasmanian Adult Literacy Plan 2010–15*
Mar	No. 8 of 2012–13	National Partnership Agreement on Homelessness
Mar	No. 9 of 2012–13	Royal Derwent Hospital: site sale
May	No. 10 of 2012–13	Hospital bed management and primary preventive health
May	No. 11 of 2012–13	Volume 5 — Other State entities 30 June 2012 and 31 December 2012
Aug	No. 1 of 2013–14	Fraud control in local government
Nov	No. 2 of 2013–14	Volume 1 — Executive and Legislature, Government Departments, Tasmanian Health Organisations, other General Government Sector State entities, Other State entities and Superannuation Funds
Nov	No. 3 of 2013–14	Volume 2 — Government Businesses, Other Public Non-Financial Corporations and Water Corporations
Dec	No. 4 of 2013–14	Volume 3 — Local Government Authorities
Dec	No. 5 of 2013–14	Infrastructure Financial Accounting in Local Government
Jan	No. 6 of 2013–14	Redevelopment of the Royal Hobart Hospital: governance and project management
Feb	No. 7 of 2013–14	Police responses to serious crime
Feb	No. 8 of 2013–14	Analysis of the Treasurer's Annual Financial Report 2012-13
May	No. 9 of 2013–14	Volume 5 — State entities 30 June and 31 December 2013, matters relating to 2012–13 audits and key performance indicators
May	No. 10 of 2013–14	Government radio communications

Current projects

Current projects

Performance and compliance audits that the Auditor-General is currently conducting:

Title	Audit objective is to ...	Annual Plan of Work 2013–14
Security of Information and Communications Technology (ICT) infrastructure	... assess the effectiveness of security measures for ICT infrastructure and its functionality.	Page 11 Topic No. 3
Processes to ensure teacher and teaching quality in public high schools	... assess the quality of teaching in public high schools.	Page 11 Topic No.2
Motor vehicle fleet usage and management	... determine whether use by selected government departments of vehicles is effective, efficient and economic. The audit will also consider allocation and use of motor vehicles complies with government guidelines and whether fleets are properly managed.	Page 13 Topic No. 2
Follow up audit	... ascertain the extent to which recommendations from reports tabled from October 2009 to September 2011.	Page 12 Topic No. 4
Quality of Metro bus services	... look at the quality of public transport services provided by Metro Tasmania.	Page 12 Topic No. 8
Budgeting of capital works	... look at the effectiveness of Treasury's capital works budgeting processes.	Page 11 Topic No. 1

Audit Mandate and Standards Applied

Mandate

Section 17(1) of the *Audit Act 2008* states that:

> 'An accountable authority other than the Auditor-General, as soon as possible and within 45 days after the end of each financial year, is to prepare and forward to the Auditor-General a copy of the financial statements for that financial year which are complete in all material respects.'

Under the provisions of section 18, the Auditor-General:

'(1) is to audit the financial statements and any other information submitted by a State entity or an audited subsidiary of a State entity under section 17(1).'

Under the provisions of section 19, the Auditor-General:

'(1) is to prepare and sign an opinion on an audit carried out under section 18(1) in accordance with requirements determined by the Australian Auditing and Assurance Standards

(2) is to provide the opinion prepared and signed under subsection (1), and any formal communication of audit findings that is required to be prepared in accordance with the Australian Auditing and Assurance Standards, to the State entity's appropriate Minister and provide a copy to the relevant accountable authority.'

Standards Applied

Section 31 specifies that:

'The Auditor-General is to perform the audits required by this or any other Act in such a manner as the Auditor-General thinks fit having regard to –

(a) the character and effectiveness of the internal control and internal audit of the relevant State entity or audited subsidiary of a State entity;

(b) the Australian Auditing and Assurance Standards.'

The auditing standards referred to are Australian Auditing Standards as issued by the Australian Auditing and Assurance Standards Board.

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