

**EVALUATION OF THE
PRIMARY HEALTH SERVICES**

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Health Services Research and Evaluation Program

Turning Point Alcohol and Drug Centre

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ACRONYMS

A&D	Alcohol and Drugs
ADIS/SWITCH	Alcohol and Drug Information System/Statewide Information Technology for Community Health
Anex	Association for Prevention and Harm Reduction Programs, Australia
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
BBV	Blood Borne Virus
CAH	Centre for Adolescent Health
CAHMS	Child and Adolescent Mental Health Services
CBD	Central Business District
CDW	Community Development Worker
CLE	Community Legal Education
DHS	Victorian Department of Human Services
DOL	Drug Outreach Lawyer
DPSB	Drugs Policy and Services Branch
FLS	Fitzroy Legal Service
GP	General Practitioner
HCT	Health Care Team
MBBS	Bachelor of Medicine/ Bachelor of Surgery
MhOS	Mobile health Outreach Service
MOU	Memorandum of Understanding
NSP	Needle and Syringe Program
NYCH	North Yarra Community Health
OHS	Occupational Health and Safety
PERIN	Penalty Enforcement by Registration of Infringement Notice
PHS	Primary Health Service/s
QICSA	Quality Improvement & Community Service Accreditation
RCH	Royal Children's Hospital
RDNS/HPP	Royal District Nursing Service/Homeless Person's Program
RHED	Resourcing Health and Education in the Sex Industry
SAAP	Supported Accommodation Assistance Program
SEADS	South East Alcohol and Drug Clinic
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TPADC	Turning Point Alcohol and Drug Centre
VIVAIDS	Victorian Drug Users Group
YMCA	Young Men's Christian Association
YPHS	Young People's Health Service
YSAS	Youth Substance Abuse Service

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EXECUTIVE SUMMARY

This project reviewed the twelve primary health services and ancillary programs funded under the Local Drug Strategy 'Saving Lives' policy. These services target injecting drug users (among others) in municipalities in metropolitan Melbourne identified as having high incidences of drug use and related problems. The overarching objective of the primary health services is to *'provide services that lead to better health outcomes for their intended clientele'* (DPSB, 2006). Whilst guidelines were provided on the services to be delivered, the primary health services with their relevant municipal bodies were encouraged to develop their own service model in response to the local needs of their community.

This project describes strategies currently used by the primary health services to meet their aim of providing services that lead to better health outcomes for their clients. The Drugs Policy and Services Branch at the Victorian Department of Human Services identified eight areas of interest for this project (*accessibility of the services, the provision of a holistic model of care, empowerment model of care, assessment and intervention plans, staff profile, continuity of care, access to other services and data collection*). Methods comprised a self-assessment questionnaire for managers of each service, a snapshot survey of clients at the fixed site primary health services and analysis of reporting data and existing service information.

A Steering Committee oversaw the project from start to completion and there was a collaborative review process with the committee. Representatives from each agency were invited to review this report and the supplementary agency profile on their service.

The clients of primary health services

Data suggest that people attending primary health services are mainly injecting drug users in their twenties. Most people attending are born in Australia and do not report Aboriginal or Torres Strait Islander heritage. More men than women attend however clients of the Primary Health Services are still more likely to be female than those attending a Needle and Syringe Program.

Clients reported a higher level of contact with the service system than was found in a needs analysis conducted in 1999 with a similar population. The majority reported contact with at least a General Practitioner in the six months prior to being surveyed. However, more than two-thirds of respondents said that if their primary health service were not available, they would not go anywhere else.

Accessibility of the primary health services

Primary health services use a variety of strategies to increase accessibility and help clients feel welcomed. Managers and clients report that their services are a safe place for clients. Assistance is predominantly available on a non-appointment basis and clients are able to obtain respite in various means at all services.

Holistic model of health care

A broad variety of health care is available at the primary health services. This includes acute drug overdose responses, general and specialised health care, nursing care, mental health, dietary advice, gender-specific care as well as practical supports.

Empowerment model of care

Services report having a collaborative approach with clients about their health care and other issues. Some report client participation in the planning, delivery and evaluation of their service.

Assessment and intervention plans

Client assessment and intervention plans are conducted according to local protocols. At some sites, the processes are more formalised and may involve the use of tools and/or duty workers.

Staff profile of the primary health services

The original model for the fixed site primary health services included a requirement (which later became to a recommendation) to have a minimum of two health professionals at the service, including either a General Practitioner or a nurse. In addition to these staff, the services employ (or are visited by) a range of staff who can address issues of nutrition, women's health and counselling. The majority of services also employ mental health clinicians.

Continuity of care

Primary health services facilitate good continuity of care, both within their own service and externally. This occurs in a variety of ways ranging from clear communication with internal and external staff to having visiting staff or providing services for clients of another service.

Client access to other services

The manager and client data suggest that access to other services is well supported. This is facilitated by good links with other services and appropriate levels of support during referrals.

Data collection

There are major limitations in the way reporting data have been collected from the primary health services to date. Data from the Alcohol and Drug Information System (ADIS) in 2005 should be read with caution.

Conclusions and recommendations

As the aim of this report is to describe strategies primary health services are using in the eight areas of interest, the conclusions and recommendations outline different approaches that may be useful in other primary health services.

Introduction

In 2001, as part of the Local Drug Strategy 'Saving Lives' policy, the Victorian State Government provided funding to establish primary health services in five areas of Melbourne with high drug usage rates: the City of Greater Dandenong; the City of Maribyrnong; the City of Melbourne; the City of Port Phillip; and the City of Yarra. According to the Local Drug Strategy Policy Paper (see Appendix 1), the goal of these services in the 'hot spot' municipalities was *'To provide a primary care service to enhance the health and welfare of street based injecting drug users and reduce the public nuisance associated with street drug use'* (DHS, 2001).

The primary care services were given some autonomy in their design and development, with municipalities responsible for choosing the model of service to be provided. However, the initial guidelines outlined a minimum of services to be provided by each of the primary care services:

- *"provision of two health professionals (at least one general practitioner or nurse) to provide primary health care services to street based injecting drug users, such as responding to their physical needs (eg. blood-borne viruses; vein care; personal hygiene; wound care etc).*
- *capacity to provide primary care interventions to street based injecting drug users such as mental health, dietary, women's health, and counselling.*
- *provision of a low-stimulus, non-clinical environment in which street based drug users can recover from acute, unwanted drug effects. Sensitivity to gender and cultural issues will be necessary.*
- *provision of first-aid training to all relevant staff*
- *development of assessment, referral processes and protocols with the mobile overdose response workers, drug safety workers, direct response to overdose program (DROP), Metropolitan Ambulance Service, Victoria Police, and other relevant service providers*

Consideration should also be given to providing a range of other services including:

- *dentist*
- *housing*
- *legal*
- *employment and training*
- *food service."* (DPSB, 2001, p9)

These were later revised to be suggestions instead of requirements. Services were encouraged to consider whether these were useful in meeting the needs of their local clients. More recently, six additional programs have been funded as Primary Health Services. Two of these are a similar fixed primary health service and the other four provide services ranging from counselling to legal services.

Turning Point Alcohol and Drug Centre

In October 2005, Turning Point Alcohol and Drug Centre was commissioned by Drugs Policy and Services Branch (DPSB) to undertake an evaluation of Primary Health Services in Victoria. The scope of this evaluation is the twelve services funded by Drugs Policy and Services Branch as Primary Health Services. The evaluation involves Adult and Youth Primary Health Services (PHS) at seven locations. These are:

- Access Health (City of Port Phillip)
- Health Works (City of Maribyrnong)
- Living Room (City of Melbourne)
- Next Door (City of Yarra)
- Foster St Clinic (City of Greater Dandenong)
- Young People's Health Service (City of Melbourne)
- Youth Substance Abuse Service (City of Yarra)

It also involves a review of five ancillary programs funded under the Primary Health Services pool. These services are:

- Youth Substance Abuse Service Evening Outreach Nurse (City of Melbourne)
- Youth Substance Abuse Service Evening Outreach (City of Yarra)
- Fitzroy Legal Service Drug Outreach Lawyer (City of Yarra)
- North Yarra Community Health Alcohol and Drug Counsellor (City of Yarra)
- Inner South Community Health Centre Mobile Health Outreach Service (City of Port Phillip)

1.1 Aim

The aim of the evaluation is to describe the strategies, if any, these twelve services are using to meet the aim of the Primary Health Services: *'to provide services that lead to better health outcomes for their intended clientele'*.

1.2 Evaluation questions

Drugs Policy and Services Branch nominated eight areas of interest for this evaluation and asked:

1. Is the service accessible to the target client group?
 - 1.1. Does the service offer a safe place where street-based drug users can access assistance and receive attention on a non-appointment basis?
 - 1.2. Does the service offer a safe place where street-based drug users obtain respite from drug use and the drug-using environment?
2. Is a holistic model of health care provided?
 - 2.1. Are facilities provided to enable client recovery from acute, unwanted drug effects?
 - 2.2. Are primary health care services, involving GPs and nurses, available?
 - 2.3. Is there capacity to provide mental health, dietary, women's health and counselling services?
 - 2.4. Are practical support facilities in place and accessible to clients (i.e. laundry facilities, showers, mail pick-up, telephone)?
3. Does the service employ an empowerment model that equips clients to take an active role in improving their health and wellbeing?
4. What approaches are used for assessment and intervention/care plans?
5. What is the staff profile (including management) of the primary healthcare service?
 - 5.1. What is the management structure of the Primary Health Service?
 - 5.2. What is the range of qualifications held by staff?
 - 5.3. Do all staff have first-aid training?
6. Is continuity of care supported by facilitating the collaboration of core, colocated and sessional staff?
7. Is client access to other services (e.g., employment, housing, financial) supported? How?
8. What data collection strategies are in place?

2 Methods

This evaluation draws on a variety of data sources including a self-assessment questionnaire for managers, a client satisfaction survey, reporting data and existing service information.

2.1 Guiding mechanisms

A project steering committee was convened by the Drugs Policy and Services Branch to oversee this project. Members of the committee included representatives from Anex (Association for Prevention and Harm Reduction Programs Australia), VIVAIDS (Victorian Drug Users Group), Drugs Policy and Services Branch, Regional Alcohol and Drug Coordinators and Turning Point Alcohol and Drug Centre. The committee approved the project design, tool development, draft and final reports.

2.2 Self-assessment questionnaire for managers

A 66-question self-assessment questionnaire based on the evaluation questions was used with the twelve agencies ('manager's survey'). A draft version was developed by the evaluators, approved by the Steering Committee and then piloted by two of the agency managers. The questionnaire was approved by Turning Point Alcohol and Drug Centre's internal ethical facilitation process. The questionnaire was then emailed with a plain language statement and consent form to the manager of each service. The manager of each service had responsibility for the survey but could delegate completion as they saw fit. The agencies had 2 weeks to complete the surveys. They could be returned via email, on a CD or in hard copy. Please see Appendix 2 for the self-assessment questionnaire.

2.3 Client snapshot surveys

A 10-question self-administered survey ('client survey') was used with a convenience sample of at least ten clients per fixed Youth and Adult Primary Health Service (n = 76). In addition to basic demographics questions, the survey asked clients:

- How often you come here
- Why you first came here
- Which services you use here
- The best and worst thing about this Primary Health service
- Other services you have used in the past six months

Surveys were printed onto brightly coloured paper and placed in a prominent space at each of the fixed sites under a large poster. When clients had completed their survey, they posted them into a sealed box that was collected by the evaluators. There were no incentives for clients to complete the surveys. Surveys were also translated into Vietnamese, Arabic and Somali; the three most common languages other than English spoken by clients. These translations were conducted by the Department of Human Services. One survey was completed in Vietnamese and was translated back to English by a Vietnamese speaking Turning Point staff member.

Please see Appendices 3-6 for the client survey in English, Arabic, Somali and Vietnamese.

2.4 Reporting data

Service utilisation and provision data are collected through the Department of Human Services reporting software (Alcohol and Drug Information Systems, ADIS) for five of the twelve Primary Health Services. Data are collected on both registered and unregistered clients. Data for registered clients in the 2005 calendar year are used throughout this report. The services who used ADIS for both registered and unregistered clients in 2005 are Foster Street, Health Works, Next Door, Living Room and YSAS' Fitzroy Day Program and Primary Health Service (who provide data to the ADIS system using an internal software system). In October 2005 Young People's Health Service also started using ADIS to record registered and unregistered clients and the Mobile health Outreach Service (MhOS) started submitting data via ADIS for unregistered clients. Data from these two services are generally not included in the summary data provided in this report.

Access Health, the alcohol and drug counsellor at North Yarra Community Health, the YSAS Evening Outreach and Evening Outreach Nurse and the Fitzroy Legal Service Drug Outreach Lawyer provide their reporting data through written reports.

The Department of Human Services provided aggregate table data for services that report via ADIS and services who provided comparable data. Where possible information from written reports has been included.

2.5 Existing service information

Additional information (such as annual reports) provided by the DPSB and agencies were used to check, clarify and triangulate survey and quantitative reporting data.

2.6 Analysis

Quantitative results from the self-assessment questionnaire, client survey and reporting data were analysed for descriptive statistics using Microsoft Excel and a quantitative software package (SPSS 11.0_{TM}). Qualitative results were analysed for content and themes using a qualitative software package, Nvivo 7_{TM}.

2.7 Collaborative review process

The Steering Committee and the managers of each service were invited to provide comments on the draft report. The managers of each service were also invited to read their individual chapter to ensure their services were accurately portrayed.

2.8 Limitations of the data

Data collected through the ADIS have two major limitations. Not all services use the ADIS software and definitions of registered and unregistered clients are inconsistent across agencies. ADIS data are discussed further in section 3.10 'Data Collection Strategies'.

Self-report data are limited by the capacity of the respondent to accurately remember and report their responses. In the agency self-assessment questionnaire, supplementary questions were written to elicit further information. Managers were invited to review the overview report and the chapter relating to their service to ensure they were accurately represented.

The client survey was conducted with a convenience sample of ten clients per fixed site and is intended to provide a 'snapshot' only. This is not a representative sample and these data should be read as indicative only. Use of these methods allowed this project to access the best information possible within the scope of this project.

Recognising the limitations of the methods individually, a multiple methods approach was used so that the sources of data could be strengthened through triangulation.

3 Findings

This section reports on ten areas: a description of the services, a description of clients attending and findings for each of the eight evaluation questions. The services are shown below by municipality.

3.1 Descriptions of primary health services by municipality

Managers of each service were asked to describe their service, including broad information such as philosophy and goals, target groups, staff profile, auspice information and proportion of their service's funding supplied by DHS under the Local Drug Strategy funding stream. Information for this section predominantly comes from the manager's surveys with some supplementary material such as annual reports. Funding information by Local Government Area was provided by the Drugs Policy and Services Branch.

3.1.1 City of Greater Dandenong

3.1.1.1 Foster Street Clinic

In 2005-2006, the Foster Street Clinic at South East Alcohol and Drug Services (SEADS) received 100% of the City of Greater Dandenong's funding for Primary Health Services.

3.1.1.1.1 Philosophy and goals

South East Alcohol and Drug Services are based on a harm minimisation philosophy. SEADS is committed to working with all clients who seek assistance to reduce the harms arising from their own or significant others' use of alcohol and other drugs, regardless of level of dependence or choices regarding these substances. An individual's right to quality health care regardless of choice of lifestyle is central to their ethos. Goals of the service include:

- the provision of high quality, accessible, holistic health care services, which uses consumer feedback in its development and review;
- continually improve processes to attain an integrated service system;
- manage within budgets;
- achieve performance targets;
- strengthen the financial capacity of the service; and
- foster the well being, satisfaction and professional growth of staff.

3.1.1.1.2 Target group

SEADS provides services to adults and young people with illicit drug problems and presenting health issues. The primary target group is street based intravenous drug users. SEADS is predominately available to service users from the City of

Turning Point Alcohol and Drug Centre

Greater Dandenong but the service provides support to people with drug problems from a wider range of locations where possible.

3.1.1.1.3 Staff profile

The team at SEADS includes a Program Manager, Team Leader, Naturopath, Head Counsellor, Sexual Health Nurse, Myotherapist, General Practitioner, Care Co-ordinator and an Art Teacher.

3.1.1.1.4 Funding sources

Foster Street is auspiced by Southern Health and funding is received from Department of Human Services under the Local Drug Strategy funding stream.

For more information on the Foster Street Clinic, see the supplementary agency profile.

City of Maribyrnong

3.1.1.2 Health Works

In 2005-2006, Health Works received 100% of the funding for Primary Health Services allocated to the City of Maribyrnong.

3.1.1.2.1 *Philosophy and goals*

The overarching philosophy of Health Works is based on harm reduction, community development, social model of health and a multidisciplinary team approach.

3.1.1.2.2 *Target group*

Health Works provides services to injecting drug users who live in and/or access services within the western metropolitan region of Melbourne. This includes street-based injecting drug users who require assistance with health, wellbeing and psychosocial issues. To be eligible the person must be an injecting drug user, however services are not denied to people using other drugs.

3.1.1.2.3 *Staff profile*

Health Works comprises three teams. The Health Care Team (HCT, responsible for primary health care), the Needle and Syringe Program (NSP) Team and the Education Team. The Health Works team includes a Program Manager, Receptionist/Administrator, Team Leader/Community Health Worker, General Practitioner, Community Health Nurse/Generalist Counsellor, Community Health Worker, Community Health Nurses, Graduate Nurse (a new Graduate rotating every 4 months from Western Hospital) and a visiting Infectious Diseases Physician.

3.1.1.2.4 *Funding sources*

Health Works is a program of the Western Region Health Centre and received approximately 98% of its funding from DHS, under the Local Drug Strategy funding stream and small annual one-off support grants in 2005/06 from Papscreen Victoria and Maribyrnong City Council.

For more information on Health Works, see the supplementary agency profile.

3.1.2 City of Melbourne

In 2005-2006, Living Room received 72% of the funding for Primary Health Services allocated to the City of Melbourne.

3.1.2.1 Living Room

3.1.2.1.1 *Philosophy and goals*

Living Room Primary Health Service is governed by the principles of harm reduction; community development and client centred primary health care. Living Room provides medical and first aid to anyone presenting at the service. The service aims to have a significant impact on the public health issues related to blood-borne viruses for both the individual and the community as a whole.

3.1.2.1.2 *Target group*

The target community is people who inject drugs and other marginalised people of all ages and from culturally and linguistically diverse backgrounds. The service strives to promote optimal health and well-being to people who inject drugs and other marginalised people in the Central Business District.

3.1.2.1.3 *Staff profile*

The service is staffed by a Manager, Administration Officer, two Community Health Nurses, six Drug Safety Workers, two General Practitioners and a Mental Health Worker.

3.1.2.1.4 *Funding sources*

Living Room is part of Youth Projects, a not for profit organisation that provides services aimed to assist the youth and families within the Inner, North and Western suburbs of Melbourne. The Department of Human Services, through the Local Drug Strategy funding stream provides approximately 80% of the service's funds. Additional funding sources include the Commonwealth Department of Health and Ageing, under the At Risk Youth program (0.1%), Youth Projects (20%) and Medicare (1%).

For more information on Living Room Primary Health Services, see the supplementary agency profile.

3.1.2.2 Young People's Health Service

In 2005-2006, the Young People's Health Service received 17% of the Primary Health Funding allocated to the City of Melbourne.

3.1.2.2.1 Philosophy and goals

Young People's Health Service (YPHS) is a nurse led health service. The service is based on a social model of health, which provides opportunistic and strategic health intervention. Young People's Health Service clinical services are provided from Frontyard, a specialist service for homeless youth located in Melbourne's central business district. The service recognises that social inequalities are a key determinant of ill health and work needs to consider both the causes and impacts of social inequality. YPHS aims to be as accessible and acceptable to young people as possible.

3.1.2.2.2 Target group

Young People's Health Service targets young homeless people between the ages of 12-22 years but also cares for young adults up to the age of 25.

3.1.2.2.3 Staff profile

The Young People's Health Service team consists of a full time Nurse Practitioner¹/ Coordinator, a Registered Nurse/Health Promotion Co-ordinator and Registered Nurse. Part time staff include a Registered Nurse, Social Worker, Youth Peer Worker, Administrative Assistant, and weekly visits by General Practitioner and Paediatrician/Adolescent Fellow. Not all of these positions are funded with Local Drug Strategy funding.

3.1.2.2.4 Funding sources

Young People's Health Service is a program of the Centre for Adolescent Health, which is affiliated with The Royal Children's Hospital. The Royal Children's Hospital provides some financial support for overheads.

For more information on the Young People's Health Service, see the supplementary agency profile.

¹ This is a relatively new role and is defined by the Nurses Board of Victoria as incorporating 'core nursing components including advanced clinical assessment and treatment approaches, education, counselling, research, quality improvement, administration and management and may include prescribing medications, initiating diagnostic imaging and laboratory testing, approving absence from work certificates, referring to specialists and admitting and discharging consumers. ([http://www.nbv.org.au/nbv/nbvonline1.nsf/\\$LookupDocName/student_information](http://www.nbv.org.au/nbv/nbvonline1.nsf/$LookupDocName/student_information), accessed June 2006)

3.1.2.3 Youth Substance Abuse Service Primary Health Outreach Nurse

In 2005-2006, the YSAS Primary Health Outreach Nurse received 11% of the City of Melbourne's Primary Health Services funding allocation.

3.1.2.3.1 Philosophy and goals

The Youth Substance Abuse Service (YSAS) is a statewide service for young people 12–21 who are experiencing significant problems with their alcohol and/or drug use. The Primary Health Outreach Nurse provides primary health care through a van in the CBD several evenings a week. Goals of the service include improving availability and access to an effective drug withdrawal service in a community based setting and providing opportunistic Primary Health Care to young people with problematic substance use issues.

3.1.2.3.2 Target group

The Primary health Outreach Nurse Program make contact primarily with young people aged 12–21 who are experiencing significant problems with their alcohol and/or drug use

3.1.2.3.3 Staff profile

The Primary Care Outreach Nurse is a Registered Nurse.

3.1.2.3.4 Funding sources

The YSAS Primary Health Outreach Nurse is solely funded by DHS through the Local Drug Strategy funding stream.

For more information on the YSAS Day Program and Primary Health Centre, the Primary Health Outreach Nurse and the Yarra Evening Outreach Nurse, see the supplementary agency profile.

3.1.3 City of Port Phillip

3.1.3.1 Access Health

In 2005-2006, Access Health received 83% of the Primary Health Service funding allocated to the City of Port Phillip (DPSB, 2006).

3.1.3.1.1 Philosophy and goals

Access Health embraces a primary health care philosophy. Primary health care is offered from a social framework, with a focus on multidisciplinary teamwork, research and client participation and self-determination. The service endeavours to collaborate with a range of relevant health and support services in order to provide quality health care that facilitates eventual client linkages into mainstream services.

3.1.3.1.2 Target group

The service provides accessible, responsive primary health care to marginalised street based injecting drug users, street sex workers and people experiencing homelessness. To be eligible the clients must have links to the City of Port Phillip.

3.1.3.1.3 Staff profile

Access Health is staffed by a manager, team leader/health promotion worker, Indigenous Access worker, Drug Educator, General counsellor, General Practitioner, Psychiatrist, three Community Health Nurses, two Drug and Alcohol counsellors, two Sexual Assault counsellors and three Duty Social workers. Many of the positions are employed by other agencies and the majority of staff have first aid qualifications.

3.1.3.1.4 Funding sources

Access Health sits under the Salvation Army Crisis Services umbrella and is funded by the Department of Human Services through the Local Drug Strategy funding stream. Since 2004 Access Health has received three one off grants, one from DHS and two from the Salvation Army.

For more information on Access Health, see the supplementary agency profile.

3.1.3.2 Mobile health Outreach Service

In 2005-2006, MhOS received 17% of Primary Health Service funding allocated to the City of Port Phillip.

3.1.3.2.1 Philosophy and goals

The Mobile health Outreach Service (MhOS) is part of Inner South Community Health Service. Inner South Community Health Service is committed to strengthening the health and wellbeing of diverse communities, providing innovative, responsive and targeted health services and taking a key role in advocacy and policy direction. The guiding principle governing the service is integrity. Mobile health Outreach Service is an integrated community drug safety service. The service offers and provides overdose response, arrest referral response, mobile needle and syringe delivery and collection, assertive outreach, referral and casework and community development.

3.1.3.2.2 Target group

MhOS caters for people who inject drugs, from across the South East Metropolitan and specifically within the City of Port Phillip. The eligibility criteria are people who inject drugs, or require needle exchange or safe sex equipment. The primary focus of MhOS is people who inject drugs.

3.1.3.2.3 Staff profile

MhOS is staffed by a team of experienced drug and alcohol Community Development workers who are available to meet clients on the street, in community venues, and/or discuss issues over the telephone.

3.1.3.2.4 Funding sources

The service is auspiced by Inner South Community Health Service. The service receives funds from the Department of Human Services under the Local Drug Strategy funding stream.

For more information on the Mobile health Outreach Service, see the supplementary agency profile.

3.1.4 City of Yarra

3.1.4.1 Next Door Primary Health Service for People Who Inject Drugs

In 2005-2006, Next Door Primary Health Service received 54% of the Primary Health Services funding allocated to the City of Yarra.

3.1.4.1.1 *Philosophy and goals*

Next Door is part of North Yarra Community Health Centre. The philosophy of North Yarra Community Health and Next Door relates to the World Health Organisation's Ottawa Charter of equal health services for everyone. This holistic approach to healthcare is inclusive of spiritual as well as physical aspects of each person. The goal of Next Door is to provide, as much as possible, a "one stop shop" for people who inject drugs with the objective to improve their health and welfare and reduce the problems of injecting drug use such as crime. Next Door also plays a role in public education and awareness of drug use.

3.1.4.1.2 *Target group*

Next Door specifically targets people who inject drugs that do not access mainstream medical services. To be eligible a person must identify as an injecting drug user.

3.1.4.1.3 *Staff profile*

At Next Door, a Manager, Psychiatric Nurse, Registered Nurse, Psychologist, three Community Development workers and a General Practitioner are employed on a permanent basis. A dietician, gardener and art therapist are employed on a sessional basis and the drug outreach lawyer from Fitzroy Legal Service visits the service.

3.1.4.1.4 *Funding sources*

Next Door is auspiced by the North Yarra Community Health Centre. The Department of Human Services, through the Local Drug Strategy funding stream provides the majority (90%) of funding for the primary health service, and the Commonwealth Government, through the National Illicit Drug Strategy contributes to the service. Next Door have also received small program grants from the City of Yarra.

For more information on Next Door see the supplementary agency profile.

3.1.4.2 YSAS Fitzroy Day Program and Primary Health Service

In 2005-2006, the YSAS Day Program and Primary Health Service received 20% of the City of Yarra's Primary Health Services allocation.

3.1.4.2.1 Philosophy and goals

YSAS Day Program, and Primary Health Service operates from a Primary Health Care model as documented in the World Health Organisation's Declaration of Alma Ata, 1978; and the Ottawa Charter, 1986. The overall goals of the Primary Health Service include reducing problematic drug use and its harms to young people and improving the health and well-being of young people affected by the use of alcohol and other drugs.

The *Fitzroy Day Program and Primary Health Service's* four key objectives focus on:

- encouraging participants to develop social and vocational roles in the community;
- establishing meaningful and supportive relationships;
- promoting the involvement of other professionals or significant others in the ongoing care and support of the young person; and
- improving participant's access to and use of generalist community services.

3.1.4.2.2 Target group

The Day Program targets 12-21 year olds currently experiencing problems related to alcohol or other drug use and is predominantly restricted to people eligible for YSAS service. The Primary Health clinic is also open to clients of Jesuit Social Services up to the age of 25.

3.1.4.2.3 Staff profile

The Day Program and Primary Health Service is staffed by a Manager, Senior Program Development Worker, Senior Day Program and Primary Health Staff, three Day Program and Primary Health Staff members, seven casual Day Program workers and two General Practitioners. The two Home Based and Primary Health Nurses are colocated and provide ongoing support and interventions. Sessional staff includes a masseuse, stencil artist and hairdresser.

3.1.4.2.4 Funding sources

The Fitzroy Day Program and Primary Health Service receive funding from several sources. The Department of Human Service Local Drug Strategy funding stream provides 54% and the Commonwealth Government National Illicit Drug Strategy

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provides 42%. Other sources include Medicare Individual Bulk Bill Payment contributions (3.8%), and donations (0.5%).

For more information on the YSAS Day Program and Primary Health Service, see the supplementary agency profile.

3.1.4.3 Next Door Alcohol and Drug Counsellor

In 2005, the Next Door Alcohol and Drug Counsellor received 9% of the Primary Health Services funding allocated to the City of Yarra.

3.1.4.3.1 Philosophy and goals

As part of the team at Next Door, the Alcohol and Drug Counsellor shares the philosophy of a 'one-stop-shop' for people who inject drugs with the objective to improve their health and welfare and reduce the problems of injecting drug use such as crime.

3.1.4.3.2 Target group

Next Door specifically targets people who inject drugs that do not access mainstream medical services. To be eligible a person must identify as an injecting drug user.

3.1.4.3.3 Staff profile

The Alcohol and Drug Counsellor has qualifications in art education, health counselling, psychotherapy and Drug and Alcohol Work.

3.1.4.3.4 Funding sources

The Next Door Alcohol and Drug Counsellor is solely funded by DHS through the Local Drug Strategy funding stream.

3.1.4.4 Fitzroy Legal Service Drug Outreach Lawyer

In 2005-2006, the Fitzroy Legal Service Drug Outreach Lawyer received 7.5% of City of Yarra's Primary Health Services allocation (DPSB, 2006).

3.1.4.4.1 Philosophy and goals

The Fitzroy Legal Service Drug Outreach Lawyer (DOL) employs a holistic approach to individual problems, drawing on information which can be utilised in Community Legal Education or Law Reform initiatives, and it advocates not just on an individual basis, but on broader systemic and drug law reform issues as well. The Drug Outreach Lawyer helps street-based drug users to obtain appropriate and timely legal assistance prior to criminal hearings, and work towards establishing links with support agencies before sentencing commences. The goal of the service is to identify and meet clients' legal needs at an early stage by providing street outreach and visiting various agencies. As clients face multiple legal issues, the provision of a broader range of legal assistance encompasses fines, Centrelink, victims of crime compensation applications, discrimination, and appeals to bodies such as the Mental Health Review Board. In addition, Fitzroy Legal Service provides legal knowledge and advocacy to the drug using community and promotes capacity building in the drug and health sector.

3.1.4.4.2 Target group

The DOL targets people who have existing or potential substance abuse problems and who are not currently accessing existing legal services. Priority is given to people with high needs such as young people; non-English speaking clients; clients with disabilities (including acquired brain injury); clients with dual diagnosis; homeless people and those residing in rooming houses or public housing.

3.1.4.4.3 Staff profile

The Drug Outreach Lawyer program is staffed by one lawyer with the assistance of two volunteer lawyers and one volunteer paralegal.

3.1.4.4.4 Funding sources

The Drug Outreach Lawyer program is part of the Fitzroy Legal Service.

For more information on Fitzroy Legal Service's Drug Outreach Lawyer, see the supplementary agency profile.

3.1.4.5 YSAS Yarra Outreach program

In 2005-2006, the YSAS Evening Outreach program received 10% of the City of Yarra's Primary Health Services funding.

3.1.4.5.1 Philosophy and goals

The Yarra Outreach program's main goals are around providing outreach to targeted areas, familiarising the agency with street culture, identifying, engaging and educating young substance users about YSAS and appropriate services, and networking with other agencies to promote smooth and efficient referral pathways. Outreach is conducted five times a week, sometimes in conjunction with the Drug Outreach Lawyer and may take place on trains, at other agencies, in entertainment precincts and other areas where young people congregate.

3.1.4.5.2 Target group

The Yarra Evening Outreach Program make contact primarily with young people aged 12-21 who are experiencing significant problems with their alcohol and/or drug use.

3.1.4.5.3 Staff profile

The Yarra Evening Outreach service employs a Youth Alcohol and Drug Outreach worker.

3.1.4.5.4 Funding sources

The Yarra Evening Outreach service is solely funded by DHS through the Local Drug Strategy funding stream.

3.2 Clients

This section describes the actual clients of the services using data collected through reporting data, service self-assessment questionnaires and client surveys. The reporting data are compared with age and gender data collected at Needle and Syringe Programs in 2005 to see if there are any differences between the two populations.

Agencies provide the Department of Human Services with data about the people accessing their services and the services they provide to them. At four of the fixed sites, these data were recorded in the ADIS software and analysed by the Department. At another service, there were technical difficulties transferring the data to the Department, so the data were collected and analysed onsite and the results sent to the Department. The two other fixed sites collect data through their own software and send the results to the Department (data from one service is comparable and has been added to the dataset, the other is not comparable and is used only in the chapter for that service).

There are also significant limitations in the way data are recorded which are discussed later in the report in 3.10 'Data collection strategies'.

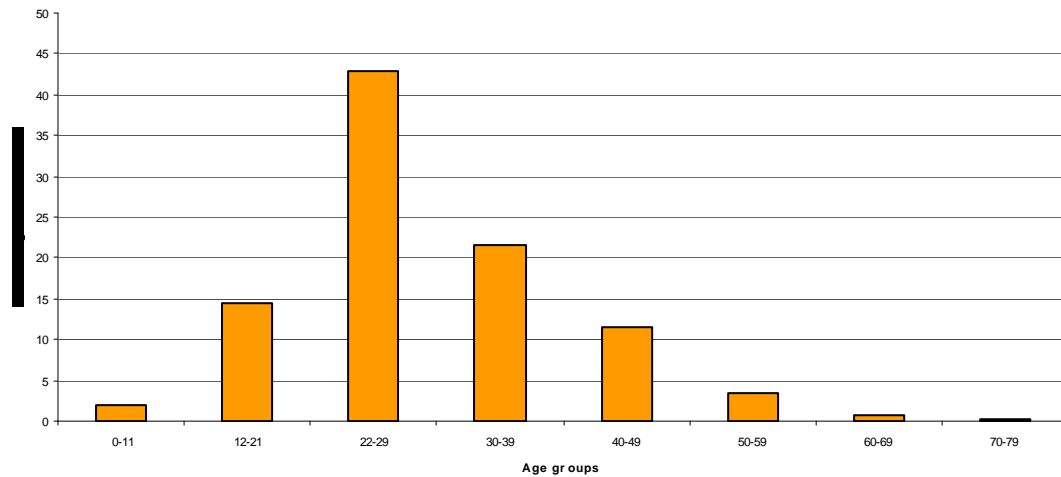
3.2.1 Service utilisation

In 2005, the data show 3,184 registered clients were recorded as accessing the Primary Health Services in Victoria and there were 25,000 visits from these registered clients. There were approximately 20,000 additional unregistered contacts (DPSB, 2006). These figures are likely to underestimate the number of clients seen by the Primary Health Services because of issues with data recording.

3.2.2 Age

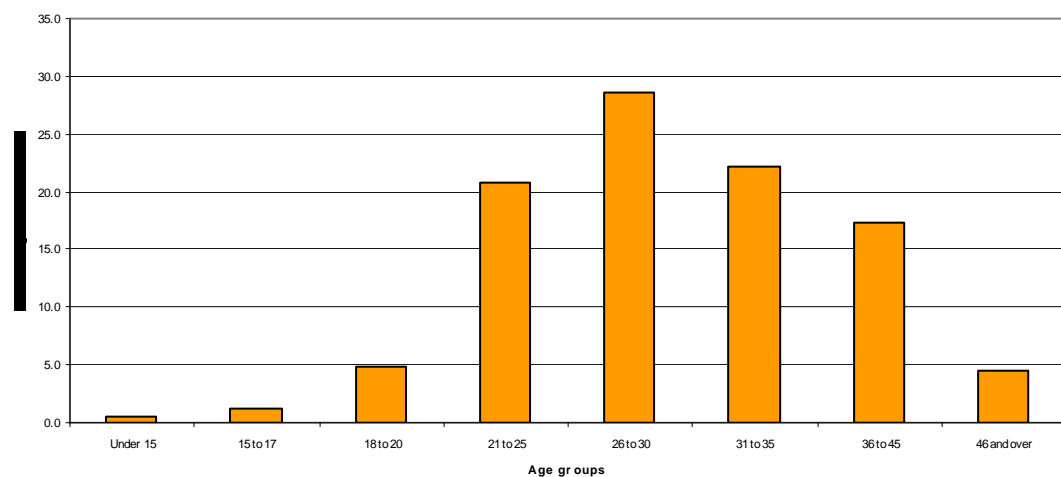
Based on data supplied by six of the fixed sites almost two-thirds (64%) of the registered clients are between 22 and 39 years. The most commonly reported age group of registered clients is 22 to 29 years (43%).

Figure 1: Percent of registered clients in 2005 by Agency, by client Age Class²



As a comparison, the most common age group for people attending an NSP in 2005 was 26 to 30 years (28.6%) and almost three quarters of the NSP clients are aged between 21 and 35 years.

Figure 2: Age of NSP clients in 2005



² NB. Agencies providing data on registered client ages are Health Works, Living Room, Next Door, Foster Street, YSAS Day Centre and Access Health.

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As the registered client data and NSP data use different age categories (see Figures 1 and 2), we cannot draw firm conclusions, however it seems that nearly half the clients for both groups are aged between 21 and 30 years. Based on the data provided NSP may see more clients aged over 30 (NSP clients 31 and over=44%; Registered clients 30 and over =37%).

3.2.3 Gender

At Health Works, Living Room, Next Door, Foster Street, YSAS Day Centre and Access Health, more men (62%) than women (38%) are registered as clients of the primary health services. The proportion of female registered clients for these services ranges from about one third (32%) to almost half (46%).

Table 1: Percent of registered clients in 2005 by Agency, by client sex

Agency Name	Female	Male	Not Stated	Total
Health Works (City of Maribyrnong)	35	65	0	100
Living Room (City of Melbourne)	32	68	0	100
Next Door (Primary Health)	33	67	0	100
Foster St Clinic (Dandenong)	46	53	1	100
YSAS Day Centre (Primary Health)	41	59	0	100
Access Health	39	61	0	100
TOTAL	38	62	0	100

This profile differs from clients attending needle and syringe programs. In 2005, more men (73%) than women (27%) are recorded as attending a needle and syringe program.

3.2.4 Ethnicity

Most registered clients of the Primary Health Services are not of Aboriginal or Torres Strait Islander descent. Of the five agencies that reported on this, the YSAS Fitzroy Day Program and Primary Health Centre and Living Room had the highest proportions of ATSI clients.

Table 2: Percent of registered clients in 2005 by Agency, by client ATSI status

Agency Name	ATSI	Non ATSI	Other/unk nown	Total
Health Works (City of Maribyrnong)	2	84	13	100
Living Room (City of Melbourne)	9	81	10	100
Next Door (Primary Health)	5	85	9	100
Foster Street (City of Dandenong)	2	86	12	100
YSAS Day Centre (Primary Health)	11	85	3	100
TOTAL	4	85	11	100

Table 3 shows that the vast majority of registered clients were born in Australia. Countries reported by less than 1% of clients are not shown here.

Table 3: Percent of registered clients by Country of Birth Category

Country of birth	%
Australia	76
Unknown	11
South-East Asia	6
New Zealand	2
South Eastern Europe	1
United Kingdom	1

3.2.5 Service reason

ADIS data for registered clients are collected on the reason for service (if the contact is for a new client, a new issue, a referral to another service or review/results only). In 2005, five of the fixed services provided information on this. As shown in Table 4, the majority of contacts were for a 'new issue', however, this ranges from 35% to 98%.

Table 4: Percent of registered clients by 'Service reason'

Agency Name	New Client	New Issue	Referral to other service	Review/results only	Total
Health Works (City of Maribyrnong)	13	37	11	38	100
Living Room (City of Melb)	13	41	8	37	100
Next Door (Primary Health)	2	90	0	7	100
Foster Street (City of Dandenong)	11	35	0	53	100
YSAS Day Centre (Primary Health)	2	98	0	0	100
TOTAL	9	58	4	30	100

3.2.6 Presenting issues

For unregistered clients, data are collected on up to three of the issues they present to a clinic with. In the second half of 2005, six of the fixed services collected ADIS data on presenting issues. In October 2005 one ancillary service commenced electronic data collection on this issue. Table 5 indicates that the most commonly recorded reason for unregistered clients presenting to primary health services in the second half of 2005 was hygiene.

Table 5: Presenting issues for unregistered clients

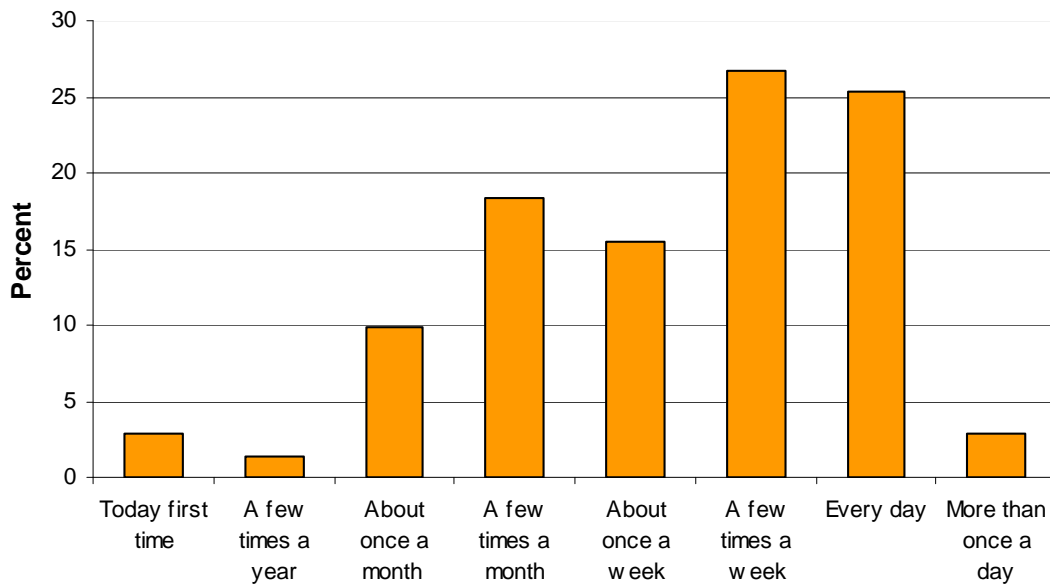
Presenting Issues	n	%
Other	3967	31.3%
Hygiene	3045	24.0%
Drug Treatment Required	1193	9.4%
General Medical	792	6.3%
Housing	690	5.4%
Mental Health	497	3.9%
Legal	444	3.5%
Financial	332	2.6%
Employment / Training	293	2.3%
HepC	236	1.9%
BBV (excluding HepC)	222	1.8%
Sexual Health	217	1.7%
Excess Consumption / OD	195	1.5%
Vein Care	167	1.3%
N/A	140	1.1%
Dental	130	1.0%
Other Wound	107	0.8%
Total	12667	100%

3.2.7 Client survey data

The client surveys from the seven main Primary Health Services (n=76) included five questions to help develop a picture of the clients attending the Primary Health Services. These were *Age*, *Gender*, *How often do you come here*, *What other services have you used?* and *If this service were not available, where would you go instead?* Not all clients answered every question therefore the sample size (n=) is included at the bottom of each table.

The average age of respondents was 31 years old (with a range of 16 to 66, n=74). More women than men completed the survey, with a small proportion of transgender/transsexual participants (56% women, 40% men, 4% transgender, n=75). About half the clients attended the service either daily or a few times a week (see Figure 3).

Figure 3: Patterns of attendance



(n=76)

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Clients were asked to describe the other services they had used in the past six months. Table 4 shows that two-thirds of clients report contact with a GP or doctor (68%) and 51% report contact with a housing service.

Table 6: Contact with other services in the past six months

General services	n (73)	%
GP/Doctor	50	68
Housing service	37	51
Community health service/s	35	48
Alcohol and drug service	33	45
Mental health service	29	40
Legal service	29	40
Hospital (Emergency department)	26	36
Dentist	24	33
Ambulance	18	25
Hospital (inpatient)	16	22
Sexual health service	11	15
Other	11	15

A smaller proportion of clients report attending other Primary Health Services.

Table 7: Contact with other Primary Health Centres

Primary Health Centres	n (67)	%
Living Room (City)	18	27
Access Health (St Kilda)	12	18
Foster St Clinic (Dandenong)	12	18
Next Door (Collingwood)	12	18
YSAS Day Program (Fitzroy)	12	18
Health Works (Footscray)	12	18
Young People's Health Service (CBD)	11	16
Other	4	6

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Interestingly, in January 2000, when a needs assessment for a primary health service was conducted in Footscray, they found that this client group had very little contact with services. Of the 196 participants in that survey, 49% reported a reluctance to use GPs and health centres in the area, 89% had difficulty finding affordable accommodation and 'utilisation rates of the various services among the participants was generally poor' (Reid, Crofts and Hocking, 2000, p x).

Whilst the client surveys did not ask whether contact with the external services was the result of their contact with the Primary Health Services, these snapshot results may suggest an increase in service contact over the past six years.

Despite these connections, when asked, 'If this service were not available, where would you go instead?' most respondents said that they would not go anywhere else.

Table 8: Client survey data 'If this service were not available, where would you go instead?'

Category	n=72(%)	Example
Nowhere	50 (69%)	'I don't know, I would be lost.' 'Insane, maybe into prison population or die' 'Wouldn't bother getting help' 'Up shit creek without a paddle.'
GP/doctors	7 (10%)	'To a doctor who isn't very resourceful and hands out medication at drop of a hat.'
Welfare	6 (8%)	
Another primary health service	3 (4%)	
Still using	2 (3%)	'I would have still been on drugs and homeless. I could have been locked up or dead.'
Other (hotel, private service)	2 (3%)	

Turning Point Alcohol and Drug Centre

As part of the client survey, clients reported on the services they had received at the fixed site primary health services. These data are also presented in relevant sections of the report. Clients said that 'At this service, I have...'

Table 9: Client survey data 'At this service, I have accessed...'

Services accessed	n (75)	%
Received free services	69	92
Used the toilet	63	84
Seen someone without an appointment	63	84
Eaten food	61	81
Seen a GP	59	79
Seen a nurse	59	79
Been helped in accessing other services	58	77
Spent time relaxing/chilling out	55	73
Participated in recreational activities	53	71
Used the telephone	51	68
Seen a counsellor	50	67
Received information about drug treatment options	49	65
Obtained information about injecting & drugs	46	61
Talked to someone about my mental health	44	59
Talked to a peer worker	41	55
Talked to someone about my sexual health.	38	51
Used a quiet space to recover if I've had too much	38	51
Gone to a group session	37	49
Obtained injecting equipment (here or at the NSP next door)	33	44
Obtained clothes	32	43
Received dietary advice	30	40
Used the showers	28	37
Spoken with workers from my cultural background	26	35
Accessed buprenorphine or methadone	25	33

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Clients were also asked to comment on the experiences they had at the primary health services. Again, clients reported that 'At this service, I have...'

Table 10: Client survey data 'At this service I have experienced...'

Experiences at the Primary Health Services	n (75)	%
Liked the staff	73	97
Felt safe	72	96
Found the space comfortable	72	96
Felt that it's a friendly environment	72	96
Liked the good facilities	70	93
Had my privacy respected	70	93
Felt that the staff don't judge me	69	92
Been easily able to get here	69	92
Talked openly to staff	67	89
Been happy with their opening hours	64	85
Felt that my health is improving	64	85

3.3 Accessibility of Services

The first question in the project brief relates to accessibility:

1. Is the service accessible to the target client group?
 - 1.1. Does the service offer a safe place where street-based drug users can access assistance and receive attention on a non-appointment basis?
 - 1.2. Does the service offer a safe place where street-based drug users obtain respite from drug use and the drug-using environment?

These will be addressed in turn using data collected from reporting data, service self-assessment questionnaires and client survey information.

The project Steering Committee defined accessibility as '*Clients feel they can receive services. Real and perceived barriers to using services are removed or reduced. Use is encouraged by appropriate service design and delivery.*' (26 April 2006).

In order to discuss accessibility for a target group, this section first revisits the target group, discusses the ways clients are currently accessing the service and looks at strategies services are using to encourage the use of their service by their general target group and any other special needs groups they identify. It then answers the two explicit questions outlined above.

3.3.1 Target groups

As discussed earlier in the service descriptions, the target group for the services is predominantly people who inject drugs with some variations.

Table 11: Target groups for the primary health services

Agency	Self-reported target group
Access Health	Marginalised street based injecting drug users, street sex workers and people experiencing homelessness with links to the City of Port Phillip.
Fitzroy Legal Service Drug Outreach Lawyer	People who have existing or potential substance abuse problems and who are not currently accessing existing legal services.
Health Works	Injecting drug users who live in and/or access services within the western metropolitan region of Melbourne.
Living Room	People who inject drugs and other marginalised people of all ages and from culturally and linguistically diverse backgrounds.
Mobile Health Outreach Service	People who inject drugs or require needle exchange or safe sex equipment across the South East Metropolitan area and specifically within the City of Port Phillip.
Next Door Primary Health Centre	People who inject drugs that do not access mainstream medical services. To be eligible a person must identify as an injecting drug user.
Young People's Health Service	Targets young homeless people between the ages of 12-22 years but also cares for young people up to the age of 25.
YSAS Day Program and Primary Health Clinic	The Day Program targets 12 – 21 year olds currently experiencing problems related to alcohol or other drug use. The Primary Health clinic is open to clients of other youth services up to the age of 25.
YSAS Yarra Evening Outreach	Primarily young people in Yarra.
YSAS Primary Health Outreach Nurse	Primarily young people in the CBD.

3.3.2 Current access

Managers were asked '*How do clients access your service? Outline the variety of processes of referral eg. informal access, walk-ins, mandated referrals etc.*'

All ten agencies involved report that clients contact them for services or they simply 'walk in'. The vast majority of agencies report receiving client referrals from local organisations (9) and from within an auspice or colocated agency (8). Six of the agencies report that clients come to their services after learning about it from other clients, friends and family. Client access is facilitated by outreach strategies in half the agencies. One agency reported that clients use their internet website as an access point. Another agency reported posting workers out to other agencies or settings to engage new clients. Corrections and mental health were referral sources for individual agencies.

ADIS data for registered clients from five fixed site services show the majority of clients report self-referring to the services (60%), followed by 'Other' (23%), Primary Health Outreach Worker (11%) and Needle and Syringe Program (5%). (We suspect the low figure for NSP referrals may mean that clients who become familiar with a service because they first use the NSP and later attend the Primary Health Service are reporting this as a 'self-referral'.)

3.3.3 Accessibility for the general target group

Managers were also asked '*How has your service made it accessible to your general target group?*'. Although there is some overlap, these can be loosely grouped into four areas: service design, service delivery, strategies and connectivity with the broader system.

Service design reported to improve access included the physical location of the service, co-location with an NSP or other service, employing good staff (including peers) and appropriate opening hours. Services report the importance of delivering services in a way that is timely, appropriate, affordable, non-judgemental, responsive to client needs and drug market trends and designed in collaboration with the clients.

Services report a number of strategies to improve accessibility. Almost half the services reported using outreach to ease access into the service and promotional material to advertise the services available. Two services reported an emphasis on engagement with clients. Targeting clients of onsite needle and syringe program was reported by two sources as a good way to connect with currently injecting drug users. Other reported measures to improve accessibility included seeing clients on a non-appointment basis, being contactable by telephone and providing material aid where available. Finally, links outside of the service were reported as improving access. Three services reported strong networks with other services (including joint outreach) as important, with one further stating that this was helpful in providing continuity of care.

3.3.4 Accessibility for special needs groups

Managers were then asked *'How has your service made itself accessible to any special needs groups? Please identify these groups and specify your strategy for each group'*

The various groups identified as having special needs by managers include culturally and linguistically diverse populations, mentally unwell, young people, women, sex workers, gay/lesbian/bisexual, physical/learning disabled, clients post-withdrawal, transgender, men, homeless and those with BBVs or HIV. Strategies for these groups are outlined in more detail in the supplementary profiles.

In the client survey, 35% of clients report that they have spoken with a worker from their cultural background. There were no questions about the other special needs groups identified here.

3.3.5 A safe place for drug users

Managers were asked '*Does the service offer a safe place where street-based drug users can access assistance and receive attention on a non-appointment basis?*'

All ten agencies report strongly agreeing (6) or agreeing (4) that their service is a safe place for street-based drug users.

When asked 'What makes this place safe or unsafe?' services reported a number of strategies that can be loosely grouped into physical and emotional safety. Steps to ensure physical safety include using protocols, having staff present in client areas, setting boundaries (including writing rights and responsibilities charters) and having skilled staff onsite who can defuse situations and manage overdoses. One agency reported encouraging clients to advise if they felt unsafe and finding them another place to wait. Strategies to make clients feel safe emotionally included providing a welcoming and non-judgemental environment, emphasising confidentiality and a place where you can have 'time out'. Other factors included building a sense of ownership of the services, being responsive to the needs of clients, using a harm reduction framework, the employment of peer workers and offering women-only times or groups. For one service, providing outreach ensures that the client can see them in a space they feel comfortable.

Three managers reported that there were times when their services could be unsafe. At one, the manager reports insufficient space during busy times, another reports that the large range of clients means competing needs, interests and vulnerabilities, Finally, one program reports that it can become unsafe when incidents occur.

95% of clients report that 'At this service, I have felt safe' and 92% report that 'At this service, I have felt that the staff don't judge me'.

3.3.6 Assistance on a non-appointment basis

Managers were asked 'What percentage of your clients access assistance and receive attention on a non-appointment basis?'

Some services do not require appointments, for instance opportunistic outreach programs. Eight of the nine agencies who could operate on an appointment basis report providing all or the majority of their services on a non-appointment basis. Client data are also high with a minimum of 75% (and average of 83%) of clients reporting that they have seen someone without an appointment for all fixed site services.

Table 12: Proportion of clients seen without an appointment

Service	Manager's survey: Proportion of clients seen without an appointment	Client survey: 'I have seen someone without an appointment'
Living Room	100%	75%
YSAS	100%	90%
Health Works	99%	88%
Access Health	92%	100%
Fitzroy Legal Service	80%	N/A*
Next Door counsellor	80%	N/A*
Next Door	Majority	80%
Young People's Health Service	Majority	80%
Foster St	20%	80%

*Client surveys were only conducted at the seven fixed sites.

3.3.7 Respite from drug use

When asked if '*Street-based drug users can obtain respite from drug use and the drug-using environment here*', nine agencies responded. The majority of these agencies strongly agree (4) or agree (4) and one service neither agrees nor disagrees. Managers report that clients obtain respite in a number of different ways. Whilst this question was asked to the ten agencies who provide Primary Health Services, it should be reiterated that four of the five ancillary services work on an outreach basis and therefore have different responses to fixed sites. Their responses are separated below.

At the fixed site services, two managers report that respite is facilitated by explicit drug-free policies (ie no using or dealing onsite). Two services report that clients attend after using drugs because they know they will be monitored and safe. To this end, two services report having quiet spaces where people can spend time. (At one, this is a dedicated area, at the other it is only available if not required for something else.) Groups, both recreational and therapeutic, are reported by another two services to be useful in providing respite. Another service provides separate areas for clients wishing to avoid active users. In order to provide respite, a well-managed space is important so clients are actively engaged and inappropriate behaviour addressed. Another service reports that simply existing and providing support gives clients solace.

For the outreach services, two services report spending time with people in cafes or quiet public spaces. (Interestingly, this does not only apply to outreach services, one fixed Primary Health Service reports using this as a way to provide care for clients not wishing to interact with other, active users.) One of the outreach services uses a van which enables clients to privately receive nursing interventions in a public place.

The agency who neither agreed nor disagreed with the statement offers scheduled groups but not a drop-in space. Intoxicated clients are only able to stay at the service if they '*do not compromise service delivery or the comfort of other clients*'.

In the client survey, 72% report that 'At this service, I have spent time relaxing/chilling out'.

3.4 Holistic Nature of Services

The second question in the project brief involved the provision of holistic care and services provided.

2. Is a holistic model of health care provided?
 - 2.1. Are facilities provided to enable client recovery from acute, unwanted drug effects?
 - 2.2. Are primary health care services, involving GPs and nurses, available?
 - 2.3. Is there capacity to provide mental health, dietary, women's health and counselling services?
 - 2.4. Are practical support facilities in place and accessible to clients (i.e. laundry facilities, showers, mail pick-up, telephone)?

These will be addressed in turn using data collected from reporting data, service self-assessment questionnaires and client survey information.

The project steering committee defined 'Holistic Care' as follows:

Service has broad understanding of health and healthcare. Model looks at many aspects of a person's life, including physical, social, mental health and others.

3.4.1 Recovery from acute, unwanted drug effects.

As with the earlier findings on respite, all twelve managers were asked about this question. The four outreach services are not designed to provide this and two did not answer the question.

Managers of all services were asked if they strongly agreed, agreed, neither agreed nor disagreed, disagreed or strongly disagreed with the statement: *'Clients can use the facilities here to recover from acute, unwanted drug effects.'*

Of the eight services who answered this, the majority of managers strongly agreed (4) or agreed (3) with this statement. One manager disagreed with the statement, who reported that although clients would be seen in a clinical room, there was nowhere for them to spend time and recover in a non-clinical setting.

If someone presents with acute and unwanted drug effects, services provide clinical assessments, which are conducted by people with a range of training, from first aid to nurses and GPs. Clients can be monitored onsite at all the fixed site services and where required, emergency treatment is provided (ie oxygen, naloxone) or an ambulance is called.

Half (50%) of clients reported that they have 'used a quiet space to recover if they've had too much'.

3.4.2 Overview of services provided

Figure 4 below provides an summary of services provided by each agency (as reported in the self-assessment questionnaire). These categories are taken from the original brief for the services.

Figure 4: Overview of services provided at fixed site services

	Access Health	Foster Street	Living Room	Next Door	YPHS	YSAS	Health Works
NSP	Δ	Δ	Δ	Δ		●	●
GP	●	●	●	●	●	●	●
Nurse	●	●	●	●	●	● +1	●
Mental health services	●	●	●	●		●	Δ
Dietary advice	●	●	●	●	●	●	●
Women's health care	●	●	●	●	●	●	●
Counselling	●	●	●	●	●	●	●
Access to a telephone	●	●	●	●	Δ	●	●
Mail pickup	●		●	●	Δ	●	●
Food	●			●	Δ	●	●
Tea & coffee facilities	●	●	●	●		●	●
Material support	●	●	●	●	Δ	●	●
Laundry			●	●		●	●
Shower access	●		●	●	Δ	●	●
Outreach	●	●	●	●		● +2	●
Practical Support ³	●	●	●	●	Δ	●	●

● = provided onsite

Δ = provided by a colocated service

³ Practical support includes phone, mail, food, tea/coffee, material aid, laundry and shower

3.4.3 Primary health care services available

Results of the self-assessment questionnaire show that NSPs are available at six fixed services and one ancillary service, either directly or through a colocated service. GP's are available at all fixed-site services for an average of 16 hours a week (range 3-31). These hours are within business hours (9:00 – 5:30). Nurses are available at eight (including the YSAS Primary Health Outreach Nurse) for 46 hours per week and one of the fixed site services is led by a nurse practitioner. Specialist infectious diseases health care is also available at one service. Of the ten (seven fixed and three ancillary) services that reported providing Primary Health Services, all provided education about drug use, infectious diseases and wound care.

Table 13: Direct care provided by Primary Health Services

Service	#	%
Education about drug use	10	100
Education about infectious diseases and prevention	10	100
Wound care	10	100
Nursing care	9	90
Sexual health treatment	9	90
STI/BBV screenings	9	90
Vaccinations	9	90
Medical (general practice)	6	60
Pharmacotherapy prescribing	5	50
Group Work-harm reduction education	3	30
Dental care	2	20

Data for six of the fixed site agencies show that registered clients see community health workers most often (35%), followed by medical practitioners (28%). 2005 ADIS data for five fixed services show that the most commonly provided service relating to alcohol and drug issues is counselling/information/assessment (41%) followed by reviews of buprenorphine (20%) and methadone (16%). According to ADIS, the most commonly provided general medical service reported for 2005 is 'other medical' (65%) and 'wound dressing /tissue trauma' (11%). See Appendix 6 for further details on registered client data.

Turning Point Alcohol and Drug Centre

Of services provided to unregistered clients at six fixed and one ancillary service in the second half of 2005, most are not recorded as this type of direct care. The most commonly recorded direct care services provided are 'information' (10.9%), 'general nursing' (3.3%), 'education' (2.9%), 'GP' (1.8%), 'advocacy' (1.8%), 'NSP' (1.5%), 'drug treatment referral' (1.2%) and 'monitoring/recovery space' (1.1%). Other services including 'vein care', 'pathology collection', 'emergency response/first aid', 'wound care' and 'massage' were recorded for less than 1% of contacts. See Appendix 7 for further details on unregistered client data.

The majority of clients (79%) report having seen a GP at their primary health service. The same number report having seen a nurse at the service.

3.4.4 Mental health, dietary, women’s health and counselling services

Mental health services are provided at five fixed site services by a range of professionals. Of those services, two report that this is provided by psychologists and psychiatrists. Dietary advice is provided at all seven fixed site services. This is often provided by GPs and nurses, although one service has a visiting dietician and one has an onsite naturopath. Women’s health care is available at the seven fixed site services and is provided by general practitioners at three services. At two services, it is provided by specialist GPs and nurses. Counselling services are available at seven services. These are mainly provided by psychologists or a community health nurse/trained counsellor. A counsellor trained in alcohol and drug and sexual assault issues is available at one of the seven services. The most common services and techniques provided for mental health, women’s health and counselling are listed below.

Table 14: Mental health, dietary, women's health and counselling services provided by Primary Health Services.

Service	#	%
Nutritional or dietary education	10	100
Personal/spiritual growth	10	100
Alcohol and drug counselling	9	90
Brief information/support	9	90
Relapse prevention	9	90
Supportive counselling	9	90
Cognitive-behavioural counselling	8	80
Art therapy	7	70
Gender-specific issues	7	70
Mental health/dual diagnosis	7	70
Regular supportive counselling	7	70
Behavioural self management	6	60
Communication skills training	6	60
Nutrition	6	60
Relaxation training	6	60
Stress management training	6	60
Assertiveness skills training	5	50
Sexual abuse counselling	5	50
Social skills training	5	50
Anger management training	4	40
Cognitive restructuring	4	40

Turning Point Alcohol and Drug Centre

Other things provided by the services include peer feedback and support (90%), promoting recreational interest or hobbies (90%), graduated reintegration to the general community (90%), follow-up or ongoing contact with clients (90%), physical exercise (80%), recreation/fitness groups (60%), general support groups (50%), drama groups (20%), spiritual or moral training (20%) and parent groups (10%).

Agencies do not specifically record visits relating to women's health. Visits relating to sexual health and gynaecological problems act as a proxy measure. ADIS data for five services show that on average, over half the sexual health services provided involved information and education. The most common gynaecological treatment provided in 2005 was pregnancy and contraceptive advice and/or prescription (42%), followed by all other gynaecological problems (22%). Based on data for four services, the most common sexually transmitted disease diagnosed is bacterial vaginosis.

Almost two-thirds of treatment recorded under HIV treatment involves pre & post-test counselling. The most common counselling service recorded in ADIS for 2005 was general counselling (54%) and other counselling (26%).

ADIS data for unregistered clients in the second half of 2005 shows that the most commonly provided services for mental health are counselling (7%) and mental health assessment (0.3%). Other related services provided were 'social interaction' (14.2%) and 'recreation' (2.0%). As with registered data, there is no specific information collected on services provided for women's health.

Over half of the clients reported that they had talked to someone at the service about their mental health (59%). Over one-third reported receiving dietary advice (40%). Half of all clients reported talking to someone about their sexual health (51%, of all clients, 50% of women and all the transgender respondents). Two-thirds of clients reported seeing a counsellor (67%).

3.4.5 Practical support for clients

Clients at seven fixed and one ancillary service have access to practical support as defined in the self-assessment questionnaire. At six services, clients can have tea and coffee, obtain essential materials (ie tampons) and use the telephone, at five services, they can have a shower and receive mail and at four services they can eat food and wash their clothes. Overall, food and nutrition is the most common service provided to unregistered clients (22.3%).

The most common practical support reported included crisis interventions and general living skills. Half the services provide vocational, legal and housing assistance.

Table 15: Practical support provided by the Primary Health Services

Service	#	%
Crisis intervention	10	100
Financial assistance	3	30
General living skills training (eg. financial management, housekeeping, personal care activities)	8	80
Housing/accommodation assistance	6	60
Legal assistance	4	40
Literacy/numeracy education	2	20
Vocational assistance	6	60
Work skills training	2	20

The ADIS data show that the most commonly provided practical support for registered clients in 2005 (at five services) were material/financial assistance (26%), assistance with legal issues (17%), accommodation (other, 14%) and assistance with education, training or employment (12%). However, when the three separate accommodation categories (emergency, other and referral for) are collapsed, accommodation overall accounts for 26% of practical support provided in 2005. Unregistered clients in the second half of 2005 were recorded as receiving practical support in the form of 'shower/washing machine' (16.5%), 'supported referral' (3.9%), 'computer use' (3.1%) and 'material aid' (2.1%).

In the client survey, clients report that they have used the toilet (83%), eaten food (80%), used the telephone (67%), obtained new clothes (42%) and had a shower (37%).

3.5 Empowerment Model of Care

The third question addressed by the project brief is about empowerment.

3. Does the service employ an empowerment model that equips clients to take an active role in improving their health and wellbeing?

The Steering Committee defined an empowerment model as:

Decisions about a client's health and their healthcare are made collaboratively between them and their service. Support and information is given to the client to enable them to change their behaviour.

In the survey, managers were asked, 'Are clients supported to have an active role in improving their health and wellbeing? If so, how does this occur?'.

All the agencies report strategies that indicate this is occurring. Giving clients control over their healthcare is reported as central for empowerment by over half the services. Managers report that this occurs through client-centred consultations, providing clients with all possible options and supporting their decisions. Similarly, building the capacity of clients is reported by about a third of managers. This occurs through using a health promotion framework, encouraging clients to do things for themselves when they are able and developing skills through education and access to resources. Providing support and referrals are also described as important by two services. One service reports including client participation in service planning, delivery and evaluation.

The vast majority of clients report that they have 'talked openly to staff' (88%) and that they feel 'their health is improving' (84%).

3.6 Assessment and Intervention Plans

This section explores assessment and care plans. The project brief includes the following question:

4. What approaches are used for assessment and intervention/care plans?

Data to answer this question come from the manager's survey and the client survey.

To address this question, managers were asked the following in the self-assessment questionnaire:

- How are the needs of clients assessed?
- How are intervention/care plans developed?
- How are these plans implemented?

3.6.1 Assessing the needs of clients

Managers report a variety of ways that the ongoing needs of clients can be assessed. Half the services reported assessing needs through direct conversations with the clients (in two cases, informally as part of engagement). Four services reported discussing the needs of clients as a team, either through regular meetings or by seeking secondary consultations with other staff members. Four agencies report using a holistic assessment tool, which can include medical and pathology testing. At two agencies, a duty worker initially assesses the needs of the client. One agency reported that clients 'self-triage', selecting the worker or discipline to meet their needs.

In overdose situations, an assessment of the situation is conducted according to local protocols. This involves a clinical assessment, which can involve nurses and GPs (as available and required), use of the Glasgow Coma Scale and other local policies and procedures. Where these indicate further assistance is required, ambulances are called.

3.6.2 Development of intervention/care plans

Managers at all seven fixed site services report that care plans are developed collaboratively, involving the client, relevant professionals and (at one agency), any additional people the client requests. One agency uses a local modification of the Health Insurance Commission care plan.

3.6.3 Implementation of care plans

The majority of managers (6) report that the plans are implemented through clinical care. They report a range of activities from making appointments and writing referrals to developing a therapeutic relationship, setting goals and working towards those goals. A review process was reported by half the agencies. Implementation of the plans was described as 'client-driven' by three managers. Having a consistent approach across staff members was reported as important at two agencies.

3.7 Staff profile

This section describes the staffing profile at the Primary Health Services. The project brief included one question on staffing:

5. What is the staff profile (including management) of the Primary Health Services and how does it compare with their key service requirements?
 - 5.1. What is the management structure of the Primary Health Services?
 - 5.2. What is the range of qualifications held by staff?
 - 5.3. Do all staff have first aid training?

This section is based on service self-assessment questionnaires and some organisational documentation where required.

3.7.1 Staff profile of services

As outlined in the introduction, the initial policy for the services stated that they were to have a *'minimum of two health professionals (at least one general practitioner or nurse) and capacity to provide primary health care interventions...such as mental health, dietary advice, women's health and counselling'* (See Appendix 1 for more details). Whilst this was later changed to a recommendation instead of a requirement, it is a useful device to show the capacity of the primary health services.

Medical care is provided at all the fixed primary health services and the YSAS Primary Health Outreach nurse program. This is normally provided by general practitioners and nurses with some specialists, including a nurse practitioner, youth health nurses and an adolescent fellow.

Mental health care is provided at most of the fixed primary health services. This is typically provided by psychologists, with one service employing a psychiatrist and another a psychiatric nurse.

Dietary advice is available at all of the fixed site services. At two primary health services, this occurs through a dietician, one employs a naturopath and the other services provide dietary advice through existing staff such as GPs, nurses and other staff.

Women's health care is provided at all fixed site services. The majority of services report using existing staff (GPs, nurses, generalist staff) to provide women's health care. One service reported employing a specialist women's health nurse.

Counselling is provided at all the fixed primary health services. This is provided by alcohol and drug counsellors, generalist counsellors, sexual health counsellors and other staff.

3.7.2 Staff qualifications and experience

The eighty-nine staff employed by the Primary Health Services hold an average of 1.2 qualifications with ten reporting no formal qualifications. The most commonly reported qualifications are Registered Nurse (19), MBBS (10), social work (8) and Certificate 4 in alcohol and other drugs (5). The people working without qualifications were typically in community development, peer worker or administrative roles.

The majority (78%) of staff report a minimum of current first aid qualifications. The five people who do not have first aid qualifications are in non-clinical roles (i.e. volunteers, sessional non-clinical staff). The two staff members with lapsed first aid qualifications are in positions where they are always likely to have currently qualified staff nearby.

Peer involvement in the services was recommended in the initial service design to improve accessibility. The employment of staff with injecting drug use experience ('peers') occurs at multiple primary health services, sometimes within larger organisations. This may have challenging implications for peer recruitment and retention within these larger organisations. For instance, organisations that may routinely carry out police checks on applicants might be reluctant to hire a person with a drug-related criminal conviction, even if they are well suited to peer work.

3.7.3 Management and governance structures

Managers were asked *'What is the management structure of your service?, Please describe any additional governance structures. How do these structures impact on your service delivery'*

Most services have some additional governance or advisory structures in place. Three report to a Board of Directors, with another two governed by their auspice more generally. Two each report to external groups (an advisory committee and a community group). One is governed by the members of their organisation and another follows the guidelines of QICSA.

These structures play different roles across the services. At some services, they have decision making capacity, for instance, reviewing any activities or procedures they deem to be risky. At others, they provide expert strategic and content advice or set the philosophical direction of the services. Two services sit within larger auspices and use their policies and procedures. Interestingly, one of these services uses a modified set, whilst at the other, the policies and procedures have been updated for the whole auspice based on the experience of the Primary Health Services. Finally, the service with the community advisory group reports that this maintains links with the community.

3.8 Continuity of Care, Collaboration and Colocation

This section addresses the provision of continuity of care, which was defined by the project steering committee as:

'Multiple needs of clients are addressed through treatment either onsite or through appropriately supported links and referrals'. (April 26, 2006)

The project brief included one question on continuity of care:

6. Is continuity of care supported by facilitating the collaboration of core, colocated and sessional staff?

Data to answer this come from the self-assessment questionnaire and the client survey.

To answer this broader question, the self-assessment questionnaire included three questions about continuity of care, which will be addressed in turn:

- Please provide an example of how you provide continuity of care to clients within your organisation.
- Please provide an example of how you provide continuity of care between your Primary Health Service and another organisation.
- Please outline your staffing profile. Include all staff who work at your service, including those directly employed, sessional and visiting staff, peer workers, volunteers and managers.

3.8.1 Continuity of care within the organisation

Half the agencies report the use of verbal updates, often in daily clinic meetings, case conferences or clinical supervision to maintain continuity and consistency of care. Similarly, about half report sharing access to client records and case notes between the immediate treatment team or more broadly between all health professionals at the service. All agencies reported that accessing client records is done according to privacy legislation. Three agencies report using a lead worker to coordinate treatment provided by that service. The use of shared care plans, where multiple clinicians develop and follow a single care plan was reported by two agencies. An alternative practice of referring internally was reported by a further two agencies. Ongoing staff training and professional development to enable consistent care between professionals was reported by two agencies. One agency shares staff between sites.

3.8.2 Continuity of care between Primary Health Services and other organisations

Half the agencies report using supported referrals to ensure a smooth transition to a new service. Again, shared care is a feature, with four agencies reporting case conferences with external agencies and three using shared care plans and/or forwarding client information (with consent). This information may be in the form of specific assessment tools or case notes. Strong inter-agency links are nurtured by three agencies and a further two agencies report maintaining regular communication. Two agencies report referring out, however they do not specify if these are supported referrals. One agency reports that they also provide primary health care to clients of another service.

3.8.3 Collaborative staffing

Managers were asked to describe their staffing profile in terms of core and visiting staff. The services are predominantly staffed by 'core staff' (people employed by the service). This ranges from as little as 25% core staff (at one ancillary service) to three services staffed only by core staff. The 23 visiting staff are predominantly nurses (5), counsellors (5) and medical staff (2). More information on the staffing profiles of each service is available in the individual service chapters.

3.9 Referrals

This section addresses access to other services. The project brief asks one question about this:

7. 'Is client access to other services (e.g., employment, housing, financial) supported? How?'

Aggregate ADIS data are available for referrals made for registered clients of five fixed services in 2005. This shows that of all referrals recorded for registered clients in 2005, almost three quarters relate to alcohol and drug treatment.

Table 16: Percentage of referrals made for registered clients in 2005

Service	%
Referral for other A&D services	21
Referral for detox (all drugs)	20
Referral to mental health service	19
Referral for Buprenorphine elsewhere	16
Referral for methadone elsewhere	15
Antenatal care / referral	2
Hep C gastro referral	2
Referral (specialist) re HIV	2
Referral to Child Protection Services	1
Referral to sexual assault service (eg CASA)	1
TOP referral	1
Colposcopy referral	1
Total	100%

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ADIS data are available for referrals given to unregistered clients for five fixed services in the second half of 2005 (and from October 2005 for one additional service). These clients are most often recorded as receiving referrals to alcohol and drug, housing and legal services.

Table 17: ADIS data on referrals made for unregistered clients

Service	#	%
A&D Service	811	20.2%
Housing Service	453	11.3%
Legal Service	376	9.4%
Other	356	8.9%
Material Aid	314	7.8%
GP	298	7.4%
Centrelink	248	6.2%
Community Health Service	236	5.9%
NSP	181	4.5%
Dental Services	116	2.9%
Mental Health	112	2.8%
Peer Education	101	2.5%
Pharmacotherapy prescriber	96	2.4%
Hospital	85	2.1%
Self-help Group	70	1.7%
Family / Relationship	62	1.5%
Sexual Health Centre	54	1.3%
Employment Service	39	1.0%
RDNS / HPP	4	0.1%
TOTAL	4012	100.0%

3.9.1 Major linkages

All services provided information on their major links with external services. Of the 153 connections (an average of seventeen per service), the most commonly reported links were with medical (19%), housing (9%), mental health (8%) and welfare (7%) services. These are explored further in each of the service chapters. Earlier, the section on 'Holistic Nature of Services' described services delivered by the Primary Health Services. Managers were also asked to indicate when clients are referred to a colocated or external service.

3.9.2 Direct care

For direct care, the services most commonly provided by a colocated service are dental, mental health, nursing and wound care. The most common external referrals are for pharmacotherapy dispensing (100%), dental care, mental health, podiatry, sexual health treatment and vaccinations.

Table 18: Direct care services provided

	Referral to a colocated service		Referral to an external service	
	n	%	n	%
Direct Care				
Dental care	4	40	9	90
Medical (general practice)	3	30	8	80
Mental health/dual diagnosis	6	60	9	90
Nursing care	6	60	5	50
Nutrition	2	20	6	60
Pharmacotherapy dispensing	0	0	10	100
Pharmacotherapy prescribing	2	20	8	80
Podiatry	3	30	9	90
Sexual health treatment	3	30	9	90
STI/BBV screenings	2	20	8	80
Vaccinations	2	20	9	90
Wound care	6	60	7	70

3.9.3 General support

The most commonly provided general support services by a colocated service are general living skills training and a graduated reintegration to the general community. Similarly, clients are referred to external services for this support as well as personal and spiritual growth.

Table 19: General support services provided

	Referral to a colocated service		Referral to an external service	
	n	%	n	%
General Support				
Aftercare / follow-up /ongoing contact with clients	8	80	8	80
Gender-specific issues	7	70	8	80
General living skills training	9	90	10	100
Graduated reintegration to general community	9	90	10	100
Peer feedback and support	5	50	6	60
Personal/spiritual growth	7	70	10	100
Relapse prevention	7	70	9	90
Vocational assistance	8	80	9	90

3.9.4 Individual support

Clients are most commonly referred to a colocated service for crisis interventions or supportive counselling. All services report external referrals for a variety of counselling (alcohol and drug, supportive, cognitive-behavioural and sexual) as well as housing and accommodation.

Table 20: Individual support provided

	Referral to a colocated service		Referral to an external service	
	n	%	n	%
Individual Support				
Alcohol and drug counselling	7	70	10	100
Cognitive-behavioural counselling	4	40	10	100
Crisis intervention	9	90	9	90
Financial assistance	6	60	10	100
Housing/accommodation assistance	3	30	10	100
Legal assistance	6	60	9	90
Sexual abuse counselling	2	20	10	100
Supportive counselling	8	80	10	100

3.9.5 Family support

In addition to support provided directly, people seeking family support are referred to a colocated service by more than two-thirds of services and to external services by the majority of services.

Table 21: Family support provided

	Referral to a colocated service		Referral to an external service	
	n	%	n	%
Family Support				
Brief information/support	7	70	9	90
Regular supportive counselling	7	70	9	90

3.9.6 Group work

The most common type of group work referred to a colocated service is general support, parent groups and cognitive-behavioural counselling. All services refer to external services for 12-step programs (like Alcoholics Anonymous), cognitive-behavioural counselling and sexual abuse groups.

Table 22: Group work and support provided

Service Component	Referral to a colocated service		Referral to an external service	
	n	%	n	%
Group Work/Support				
12-step approach	0	0	10	100
Art therapy	2	20	9	90
Cognitive-behavioural counselling	4	40	10	100
Drama groups	0	0	8	80
General support groups	5	50	9	90
Group Work-harm reduction education	1	10	3	30
Other forms of group work/support counselling (please specify):	0	0	1	10
Parent groups	4	40	9	90
Recreation/fitness groups	2	20	9	90
Sexual abuse (gender-specific) group work	1	10	10	100

Overall, all agencies either directly provide or refer elsewhere for the majority of these services. The only two exceptions are regular family support (which is not provided or referred by one service) and group drama work, which is not provided or referred by two services.

In the client survey, about three-quarters of respondents (76%) reported that they 'have been helped in accessing other services'.

3.10 Data collection

ADIS/SWITCH reporting data differentiates between registered and unregistered clients. Clients can remain anonymous and still receive assistance, however if they wish to see a GP, nurse, counsellor etc they are generally required to provide details such as name, date of birth and country of origin. (DPSB, 2006) Registered data provide more detailed information on service provision (duration of visit, practitioner seen, details of services received) whilst unregistered data provide less information (presenting issue, services received, referrals made).

This section addresses service delivery data collected by the services, in particular how clients are recorded and the difference between registered and unregistered clients.

The project brief included one question on data collection:

8. What data collection strategies are in place?

Data to answer this question are drawn from reporting data (ADIS and SWITCH) and the self-assessment questionnaire. The self-assessment questionnaire includes four questions to this effect.

- How do you record the number of clients you service?
- How do you define a 'registered client'?
- Of your total client group, approximately what proportion of these are registered?
- Please outline any differences between services delivered to registered and unregistered clients?

3.10.1 Recording clients

Both registered client data and unregistered contact data can be recorded in ADIS or SWITCH. Six of the seven fixed sites report both registered client data and unregistered client contacts to DHS using ADIS or SWITCH. One of these uses their own software that incorporates the relevant fields from ADIS. The seventh site uses specialist software to record client information and provides written reports to DHS. One service reports not recording all the clients that attend, for instance, if a person attends on a casual basis and is referred elsewhere, this is not always recorded. Of the ancillary services, one uses ADIS to report unregistered contact data to DHS, the others provide written reports.

3.10.2 Defining registered and unregistered clients

There are almost as many understandings of a 'registered client' as there are agencies. Half the services state that clients receiving clinical care are registered, however this ranges from 'attends the clinic' or 'has an appointment with a GP or nurse that will be recorded' to clients who have a care plan and a unique record number.

At three services, registration is client driven which means they are registered when they choose to be. At one of these services, the only difference between registered and unregistered clients is their level of engagement with the service, which means unregistered clients are able to see GPs). For two services, clients who have received regular non-clinical care are encouraged to register. One service counts clients as registered when they have an appointment with a GP or nurse and unregistered when they receive any other service or attend to use the facilities. The outreach services are only required to report on unregistered contacts and the Alcohol and Drug Counsellor at Next Door reports Episodes of Care for one-to-one consultations and unregistered contacts for group work.

3.10.3 Proportion of registered to unregistered clients

Managers were asked to identify the proportion of their clients who are registered. Half of them reported very high proportions (95+%, 93.3%, 90%, 80% and 'nearly all'). Other programs reported 46% and 30% registration. One service reported only that it was variable.

3.10.4 Services delivered to registered clients

Managers were asked to describe the services delivered to registered clients. This varies both in terms of services delivered and type of data collected at registration. At four services, all clients wishing to access particular services become fully registered. One agency reports that registered clients are those presenting to see a doctor or have an appointment with a counsellor. At another service, all counselling clients are registered. At another, clients are registered if they present to the clinic. Partial registration also occurs, at one agency clients are asked to provide basic details (name and date of birth) before their first clinical consultation. At three services, clients are registered when they are further along in their clinical care. At one service, a client becomes registered once they have been assessed, had a care plan developed, a unique record number provided and a file created. Two agencies report that clients are encouraged to register when their medical records need to be kept or to maintain continuity of care if more than one worker is involved in their care. Finally, one service provides all services regardless of registration and sees registration as a stage of engagement with the service.

3.10.5 Services delivered to unregistered clients

Managers were asked about services delivered to unregistered clients. Again, this varies according to service. Clinical care including wound management, blood tests and urine screens are available to unregistered clients at one service. At another, clients can remain unregistered and access basic services such as food, showers and take part in health promotion events. At one service clients are counted according to the service they receive in that visit; they are registered with a GP or counsellor but not when accessing other services. At another service, unregistered clients are either people who have only a very brief contact (education or referral) with the service or who do not wish to provide identifiable information. Similarly at another service, the only unregistered clients are those who do not wish to be registered. Three services report that any clients seen during outreach are recorded as unregistered.

4 Conclusions and recommendations

The aim of this evaluation was to describe strategies used by the twelve services funded by Drugs Policy and Services Branch as Primary Health Services 'to provide services that lead to better health outcomes for their intended clientele'.

This section presents the conclusions for each of the eight stated evaluation objectives with recommendations as appropriate. Please note, these services were established to respond to local needs using local responses. The recommendations should also be considered with the local context of each Primary Health Service in mind.

4.1 *Who are the clients of the service?*

The clients of the primary health services are predominantly injecting drug users aged in their twenties with more men than women accessing the services (the proportion of female registered clients ranges from about one third to almost half across the services). They are mainly Australian-born and not of Aboriginal or Torres Strait Islander descent.

The proportion of women registered at Primary Health Services (average 38%) is higher than the 27% reported attending needle and syringe programs in 2005. The majority of clients do not report an ATSI background or being born overseas.

The client survey respondents had more contact with services in the past six months than the drug users interviewed for a needs analysis for Primary Health Services in 2000. More than two thirds of respondents had contact with a GP or doctor in the past six months, around half had contact with housing, community health, alcohol and drug services and a significant minority had contact with mental health, legal and hospital emergency departments. Despite this increased contact, over two-thirds of respondents said that if their primary health service were not available, they would not go anywhere else. Two possible explanations are that clients access other services through the primary health services or they consider the service their 'base' and go to other services for acute or minor treatment.

Recommendation 1: DHS to fund further research to ascertain if Primary Health Services have increased access to services for injecting drug users.

4.2 Is the service accessible to the target group?

Accessibility for this service model was defined by the project Steering Committee as '*Clients feel they can receive services. Real and perceived barriers to using services are removed or reduced. Use is encouraged by appropriate service design and delivery.*' (26 April 2006).

Good attention has been paid to accessibility at all the primary health services. The primary health services are innovative in the way they encourage use of their services. This includes tangible strategies (collocation, outreach, links with other agencies) as well as a non-judgmental and informal style of service delivery suited to their clients. Clients access services by 'walking in', through referrals from local and auspice organisations, other clients, friends and family and outreach. General accessibility is enhanced by being well-located, sharing a site with an NSP or other service and using outreach and promotional materials. Improving accessibility for special needs groups mainly occurs through local initiatives such as women-only times or employing workers to target specific needs groups. A key aspect of accessibility is to provide services that are non-judgmental, appropriate and affordable.

All managers reported that their services were safe for clients. This sense of safety comes both from providing an appropriate and non-judgmental service and having a well-managed space with clear boundaries and highly skilled staff. Accessibility is also enhanced by the provision of non-appointment based assistance. All of the services provide the majority of services on this basis, except one fixed service which estimated only one-fifth of their care was delivered on a non-appointment basis. Interestingly, the vast majority of clients (75%-100%) said that they had received assistance on a non-appointment basis (even at the site that reported only providing 20% of care on a non-appointment basis).

The majority of managers said that clients could obtain respite from drug use and the drug using environment by attending their services. Some strategies they report working well were having drug-free policies (no using or dealing onsite), quiet areas, a well-managed space and recreational or therapeutic groups. The outreach services use public spaces or cafes to provide this respite. One service delivers primary health care through an outreach van so clients can receive nursing care without attending a fixed service.

4.3 Is a holistic model of health care provided?

The steering committee defined 'Holistic care' in terms of primary health services as '*Service has broad understanding of health and healthcare. Model looks at many aspects of a person's life, including physical, social, mental health and others.*'

A holistic health care response is broad and can be provided at a number of levels. Elements of good holistic care include direct care such as acute and ongoing medical care, mental health, nutrition, gender-specific responses and practical support. It also involves understanding health in the context of cultural, social and personal inequity.

Many people accessing primary health services are active drug users. In the event of a drug overdose, clients who present at a fixed Primary Health Service are clinically assessed and treated as required. At the majority of services, they are also able to spend time recovering in a non-clinical setting.

Recommendation 2: DHS to ensure that clients who have had an overdose should be able to spend time recovering onsite until they are fit to leave the premises.

GPs are available at all fixed site services for up to 31 hours a week. The majority of clients report seeing a GP at their service. The most common general medical service is 'other medical' and 'wound dressing'. Reviewing buprenorphine and methadone is recorded as more than a third of alcohol and drug issues, which is interesting as only 33% of clients surveyed report accessing buprenorphine or methadone through the Primary Health Services. This suggests that a disproportionate amount of GP time may be involved in the review of pharmacotherapies, which may reflect difficulty accessing pharmacotherapies through other prescribers.

Recommendation 3: DHS to investigate the load of pharmacotherapy prescribing and ascertain if GPs require support from local prescribers.

Nurses are available at the fixed sites and through the YSAS Primary Health Outreach Nurse for 46 hours a week. The majority of clients surveyed reported seeing a nurse. The employment of a Nurse Practitioner (an advanced nurse educated for advanced practice) at one of the fixed sites may be a useful model for other fixed primary health services to consider as a means of extending their level of health care.

Recommendation 4: DHS to support services to upskill current nursing staff to Nurse Practitioners where Primary Health Service management feels this would be useful.

Mental health services are available at five of the fixed services. This care is delivered by people from a variety of disciplines including psychiatry and psychology. Managers also report that counselling is provided at seven services by psychologists and trained counsellors. With a high proportion of alcohol and drug clients reporting mental health issues or dual diagnoses, it is encouraging that more than half the clients surveyed reported 'talking to someone about my mental health' and two thirds reported seeing a counsellor. Although this project did not specifically ask about the type of mental health care sought or provided, it is likely that some of the mental health issues experienced by clients will require more specialist interventions than can be provided by generalist staff. Access to specialist mental health staff may be useful for some services.

Recommendation 5: DHS to support services in continuing to develop their capacity to provide mental health services onsite or with an appropriately supported referral.

Dietary advice is provided at all fixed services by a variety of practitioners (dietician, naturopath, GPs and nurses). It is a positive sign that over one third of clients surveyed reported receiving dietary advice from someone at their Primary Health Service. With 80% of clients reporting that they had eaten food at the service, it is probable that other clients have learned about healthy eating by example. Some services provide healthy eating events that can be useful both for engagement and health promotion. These may be useful at other services.

Women's health care is available at all fixed sites and is typically provided by GPs or nurses. Some services also reported women-only sessions. Clients were not asked about seeking gender-specific treatment but there was a question about their sexual health. More than half the clients surveyed reported speaking to someone about their sexual health. When this is divided by gender, half the female and all of the transgendered respondents reported speaking to someone

about their sexual health. It is also important to provide health care aimed at male clients.

Practical support provided includes everyday items such as tea and coffee, necessities (i.e. sanitary products), use of a telephone or shower as well as supporting clients in crisis situations (ADIS data show that the most commonly reported practical support for registered clients is accommodation and material/financial assistance). New and second-hand clothing and material is available at some services through individual and local business donations. As well as the immediate benefit of providing practical support, this can also be the first point of engagement with a new or hesitant client.

4.4 Does the service employ an empowerment model that equips clients to take an active role in improving their health and wellbeing?

The project steering committee defined the empowerment model as:

'Decisions about a client's health and their healthcare are made collaboratively between them and their service. Support and information is given to the client to enable them to change their behaviour.'

Agencies are actively working towards empowering their clients. As well as this occurring at a micro level (i.e. per health-care decision), agencies also report building the capacity of clients more broadly by developing skills and supporting them to get the experience of doing things for themselves. One service reports client participation in key areas of service planning, delivery and evaluation. This may be useful for other services.

4.5 What approaches are used for assessment and intervention/care plans?

Longer-term assessment occurs through direct contact with clients (sometimes with the use of an assessment tool) and input from other staff. Duty workers are used at two sites for initial contact with clients. Care plans are developed collaboratively (again, sometimes with the use of a tool) and implemented through clinical care, with reviews reported in about half the agencies. Overdose assessment and management is conducted according to local protocols, including the use of ambulances and naloxone where required.

4.6 What is the staff profile (including management) of the Primary Health Services?

The initial staffing recommendations for the services stipulate a minimum of two health practitioners (at least one GP or nurse), capacity to provide primary health interventions and provision of first aid training to all staff. All fixed site services employ at least one GP and nurse, with many employing additional specialist medical staff.

Primary health interventions (defined by DPSB as mental health, dietary advice, women's health and counselling) are provided by a range of professionals at the fixed site services, although mental health treatment is not directly provided by two services (the development of mental health capacity is addressed in Recommendation 7 on page 67).

The majority of staff working at Primary Health Services have qualifications relating to their roles. Given the complex needs of clients attending the primary health services, it would be useful to ascertain if further training is required in specialist areas.

Recommendation 6: DHS to conduct needs analyses to identify any areas where further training is required and support the services in providing any such training to staff.

Whilst the majority of staff have (as a minimum) first aid training, there are a handful of people who do not have a current first aid qualification. It is good practice for staff who have one-on-one client contact to have a minimum of CPR skills.

Primary health services were designed to involve and employ peers to increase accessibility of the service to clients. These peer workers and the services that employ them may require additional support from challenges in the immediate work environment as well as criticism from people and organisations who do not understand the value of these workers and their skills and experiences.

Recommendation 7: DHS to ensure the continued use of peer workers in primary health services by supporting the workers and their managers in practical and strategic ways as requested by the primary health services.

Governance structures range from decision-making bodies to advisory groups. Whilst this was not a focus of our investigation, given the complexities involved in providing a Primary Health Service for injecting drug users, it is important that the role of any governing body is clearly articulated and negotiated. Where requested, DHS should provide support during negotiations between a primary health services and their governing body.

Recommendation 8: The role of any governance structure to be clearly articulated. DHS to provide support to agencies during negotiations as requested.

4.7 Is continuity of care supported by facilitating the collaboration of core, colocated and sessional staff?

Continuity of care is a key feature of the Primary Health Services. They were established to provide services to clients with few connections with services and through accessing low-threshold services, develop connections with the more mainstream services. Internally, services are providing continuity of care through formal and informal information sharing, some use of lead workers, shared care plans and internal referrals. Services should consider the usefulness of internal continuity of care models such as information sharing, lead workers, and care plans.

These procedures, especially shared care and information sharing also occurs with external agencies. External continuity of care is also often supported by supported referrals. One agency provides primary health care to clients of a welfare service. Services to consider the usefulness of strategies used for continuity of care with external agencies including shared care and information sharing

Five of the services report having (predominantly clinical) visiting staff at their services. This can have a number of benefits. Services can provide additional services for no or limited costs, staff can be exposed to professionals from other disciplines and clients can have access to clinicians linked with other services. This can be particularly useful as clients can become familiar with a clinician at a Primary Health Service and later attend their other (often more mainstream) service.

Recommendation 9: DHS to encourage and, where possible, facilitate the use of visiting clinicians in Primary Health Services to broaden services available and familiarise clients with other services.

4.8 Is client access to other services supported?

Agencies report many links with external services, most commonly with medical, housing, mental health and welfare services. In addition to the services provided in-house, all services report referring to either a colocated or external service for almost all service types. Primary health services should continue to facilitate client access to services, using the appropriate level of assistance required by the client at that time.

4.9 Data collection strategies

There was little consistency in the way data were collected in 2005. Data were collected using a number of tools (and sometimes multiple tools on a site) and there is great variation in the way clients are registered. There were also significant limitations with the ADIS data available, particularly relating to definitions and missing data. Modifications were made to the ADIS tool recently in consultation with the services and it has been upgraded. At time of publication, DPSB were developing business rules and guidelines to accompany the upgrade. It is important to review the quality of these data.

Recommendation 10: DHS to review primary health data after six and twelve months to ensure the upgrade has improved quality of data.

Finally, the good work of these twelve services should be recognised and funding should be continued.

Recommendation 11: DHS to continue to fund and support the ongoing provision of these twelve services.

References

Drugs Policy and Services Branch (2001) *Local Drug Strategies Directions and Priorities for Funding*.

Reid G, Crofts N and Hocking J *Needs Analysis for Primary Health Care among the Street Drug-using Community in Footscray* The Centre for Harm Reduction, Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia.