CENTRAL AUSTRALIAN ABORIGINAL CONGRESS

SAFE & SOBER SUPPORT SERVICE

Final evaluation report

2012

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Final Report

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Abbreviations

Table 1: Abbreviations and acronyms used in this report

ADSCA	Alcohol And Drugs Services Of Central Australia	GAMMA GT (GGT)	Gamma-Glutamyltransferase
AGDHA	Australian Government Department of Health And Ageing	GP	General Practitioner
ALT	Alanine Transaminase	HbA1c	*hemoglobin A1c*
AOD	Alcohol And Other Drugs	K5	Kessler Psychological Distress Scale
ASCC	Alice Springs Correctional Centre	MCV	Mean Corpuscular Volume
ASH	Alice Springs Hospital	MHACA	Mental Health Assoc. of Central Australia
AUDIT-C	Alcohol Use Disorders Identification Test Concise	MHCP	Mental Health Care Plan
CAAAPU	Central Australian Aboriginal Alcohol Programs Unit	NDRI	National Drug Research Institute
CAAC	Central Australian Aboriginal Congress	NTDHF	Northern Territory Department Of Health and Families
CAMHS	Central Australian Mental Health Service	DCF	Northern Territory Department of Children and Families
CBT	Cognitive Behavioural Therapy	PIRP	Prison In-Reach Program
CRG	Coordination Reference Group	RTO	Registered Training Organisation
DASA	Drug And Alcohol Services Association	SAS	Safe and Smart
ESG	Evaluation Steering Group	SEWB	Social and Emotional Wellbeing
FACS	Family And Children's Services	SSSS	Safe And Sober Support Service
FaHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs	SUS	Sobering Up Shelter
FASD	Foetal Alcohol Spectrum Disorder	TOR	Terms Of Reference

1. *The Safe and Sober Support Service*

1.1 Introduction

Central Australian Aboriginal Congress' (CAAC) *Safe and Sober Support Service* (SSSS) is a secondary treatment service in Alice Springs, Northern Territory, working in a holistic and culturally appropriate way to facilitate improved wellbeing for Aboriginal people experiencing the effects of harmful alcohol use. The overall goal of the SSSS is to:

> Provide a holistic and culturally appropriate counselling, therapeutic treatment and support service that strengthens the cultural, social and emotional wellbeing of Aboriginal people and their families.

The SSSS, funded through the Alice Springs Transformation Plan, by the Northern Territory Department of Health and Families, aims to support Aboriginal clients in Alice Springs experiencing harms associated with alcohol and other drug use, by providing assessment and multidisciplinary therapeutic intervention from multiple referral points in a co-ordinated, holistic way. SSSS is a multi-pronged approach to alcohol and other drugs (AOD) service delivery, and consists of four components: ambulatory casework and care coordination; the Prison In-Reach Program (PIRP); AOD sector partnerships and development; and, the program evaluation. The SSSS has two advisory committees, the Coordination Reference Group (CRG) and the Evaluation Steering Group (ESG). The CRG is tasked with overseeing the operations and implementation of the program while the ESG is responsible for advising on the evaluation of SSSS (see SSSS Program, page 121).

1.1.1 Ambulatory Casework Service

Ambulatory casework and care coordination are offered to all clients through three streams of care: advocacy, social and cultural support; structured therapy; and medical, including pharmacotherapy. The ambulatory casework service is discussed in detail from page 20.

1.1.2 AOD Sector Partnerships and Development

The Alice Springs AOD sector and related agencies have membership on the Coordination Reference Group for the SSSS, giving and receiving feedback on the Program according to the agreed Terms of Reference (page 124). The AOD sector in Alice Springs will be up-skilled through provision of ongoing training for SSSS staff in AOD. Collaborative casework with other AOD agencies and related services will strengthen the AOD sector and improve outcomes for clients. The AOD Sector Partnerships and Development is discussed in detail from page 91.

1.1.3 Prison In-Reach Program

The Prison In-Reach Program (PIRP) is a collaborative approach by four AOD service providers in Alice Springs. Three services – Holyoake, Drug and Alcohol Services Association (DASA), and Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) –

provide group programs to prisoners. All prisoners in Alice Springs Correctional Centre (ASCC) with sentences of six months or less for alcohol-related offences are eligible and may choose to participate in any or all of the programs. The PIRP, and related indicators, a discussed in detail from page 105.

1.2 Evaluation

Curtin University's National Drug Research Institute were engaged to evaluate the *Safe and Sober Support Service*. This report is the final evaluation report of *Safe and Sober Support Service*. In order to complete the report within prior to the end of the funding, the majority of the report focuses on the operation of the program from January 2010 to December 2011; however, some 2012 data has been included. The report is structured to provide a brief outline about the program, followed by achievement of the identified performance indicators.

Curtin University's National Drug Research Institute (NDRI) has been engaged to progressively evaluate the *Safe and Sober Support Service*. The evaluation process has been a progressive evaluation, focusing mainly on the process measures for the establishment of the Program. Shortly after the engagement of NDRI, an Aboriginal research associate was based in the SSSS office for almost eight weeks. During this site visit, the researcher spoke to all the current SSSS staff, and key stakeholders and agencies. Through this site visit, regular communication pathways were created, and a clear understanding of the internal and external expectations of the SSSS were gained. The evaluation framework was designed following this site visit, based on the outputs and measures identified in the original proposal and additional indicators identified through the consultation process (see Table 2, page 10). The evaluation framework was approved by the ESG in April 2011.

1.2.1 Objectives

The *Safe and Sober Support Service* has a number of identified objectives that were developed for the evaluation framework. These are:

Ambulatory Casework Service

1.1 Actively supporting and assisting Aboriginal people in Alice Springs experiencing by alcohol related harms.

1.2 Improve the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program.

1.3 Enabling clients to manage their mental health issues and reduce their alcohol consumption.

1.4 Decrease in the alcohol consumption and a change in drinking patterns of clients

1.5 Reduction in the levels of alcohol-related events experienced by SSSS clients following contact with the program.

Prison In-reach Program (PIRP)

2.1 Provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre.

2.2 Reduction in the levels of recidivism for prisoners who engage with SSSS.

AOD Sector Support and Engagement

3.1 Establishment of a well-supported interagency AOD network in Alice Springs.

3.2 Improve and build capacity within wider AOD sector [external].

Program Capacity Building

4.1 Employment and retention of well-supported and trained program staff.

4.2 Improve and build capacity of SSSS program staff [internal].

1.2.2 Evaluation Framework

The evaluation framework (Table 2) was developed by the evaluation team, through extensive consultation program staff and key stakeholders, and observation of the program in operation between September and November 2010.

Table 2: Complete Safe and Sober Support Service Evaluation Framework, as at April 2011

	Objective	As measured/ indicated by	Frequency
Ambulatory Casework Service			
1..1	Actively supporting and assisting Aboriginal people in Alice Springs experiencing alcohol related harms	Number of clients referred to the program, by source*	Quarterly
		Number of client contacts per client, by age and gender	Quarterly
		Number of clients with a completed assessment by the program (this is completed prior to the MHCP) *	Quarterly
1.2	Improve the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program	Number of treatment sessions for *each* engaged client, by stream of care (an engaged client is one who has a completed MHCP and has therefore agreed to participate in treatment beyond the initial assessment)*	Quarterly
		Number of clients being case managed*	Quarterly
		Thematic analysis of group work summary reports	Six monthly
		Thematic analysis of long term outcomes of engaging clients – alcohol consumption, general wellbeing, housing, health, & employment. *	Annually
		File audit of clients, for changes in the management of diabetes by clients, through the monitoring of: Cholesterol levels; Blood glucose levels (HbA1c); & Blood pressure*	Annually
		File audit of clients for changes in alcohol related biochemical markers such as Gamma GT, ALT and MCV	Annually
1.3	Enabling clients to manage their mental health issues and reduce their alcohol consumption	Number of clients managed on a mental health care plan (MHCP) *	Quarterly
		Amount of income generated by the program, from *Medicare*, and other sources (Courts/ DOJ) *	Quarterly
		File audit of clients, for changes in the management of depression by clients, through the monitoring of: K5 scores	Annually
		Semi-structured interviews with sample of both engaged and non-engaged program clients *	Annually
1.4	Decrease in the alcohol consumption and a change in drinking patterns of clients	AUDIT-C scores for both engaged and non-engaged clients (including relapse prevention maintenance) over time for all clients with 2 or more scores entered. *	Quarterly
1.5	Reduction in the levels of alcohol-related events experienced by ssss clients following contact with the program *NB There may be in increase in non-alcohol related service utilisation*	Change in the number of alcohol-related: * • Alcohol related and non-alcohol related presentation to Congress • ASH Emergency alcohol-related presentations • Alcohol-related admissions • Sobering up Shelter presentations • Night patrol incidents • Protective custody	Annually
		Thematic analysis of semi-structured interviews with harm reduction service providers	Annually

Prison In-reach Program (PIRP)			
2.1	Provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre	Number of alcohol rehabilitation program sessions delivered in ASCC*	Quarterly
		Number of clients engaging in (and completing) each alcohol rehabilitation program in prison*	Quarterly
		Number of PIRP clients who contact and engage with ssss following release from ASCC	Quarterly
		Thematic analysis of reports from participating service providers	Six-monthly
		Semi-structured interviews with Prison In-reach Program partners and key stakeholders	Annually
2.2	Reduction in the levels of recidivism for prisoners who engage with ssss	Quantitative analysis of alcohol-related offences and imprisonment rates in Alice Springs/ Central Australia	Annually
AOD Sector support and engagement			
3.1	Establishment of a well-supported interagency AOD network in Alice Springs	Number of clients referred to the program, by source*	Quarterly
		Number of case-managed clients across AOD services*	Quarterly
		Participation by AOD sector members in CRG meetings*	Quarterly
		Thematic analysis of program documentation [meeting minutes]	Quarterly
		Establishment of formal collaboration [service] agreements between agencies	Annually
		Semi-structured interviews with key stakeholders and program partners	Annually
		Thematic analysis of semi-structured interviews with key stakeholders and program partners	Annually
		Thematic analysis of semi-structured interviews with community members [Community focus group]	Annually
3.2	Improve and build capacity within wider AOD sector [external]	Number and type of AOD training courses offered, and level of participation	Quarterly
		Number of group self-help sessions with other service providers provided and the number of clients who participate*	Quarterly
		Thematic analysis of program documentation [training related]	Annually

Program Capacity Building			
4.1	Employment and retention of well supported and trained program staff	Thematic analysis of program documentation [Staff and CRG meeting minutes]	Quarterly
		Thematic analysis of semi-structured interviews with program staff	Six monthly
		Development of clear and appropriate program and operational procedures and documents: including referrals, case management, support, and advocacy tools.	Six monthly
		Number and progress of individual CAAC career development plans	Annually
		Thematic analysis of semi-structured interviews with program staff regarding the use and development of the MHCP/ Stay Strong Care plans	Annually
4.2	Improve and build capacity of ssss program staff [internal]	Provision of appropriate training	Quarterly
		Number and type of AOD training courses offered, and level of participation	Quarterly
		Number of AOD workers actively completing certificates II to IV in Community services – Alcohol & Other Drugs*	Six monthly
		Number of ssss program staff trained in AOD in self-management and recovery programs	Six monthly
		Number of ssss program staff receiving cultural competency up-skilling	Six monthly
		Thematic analysis of program documentation [training related]	Annually

* Denotes the original performance indicators.

1.3 Methods

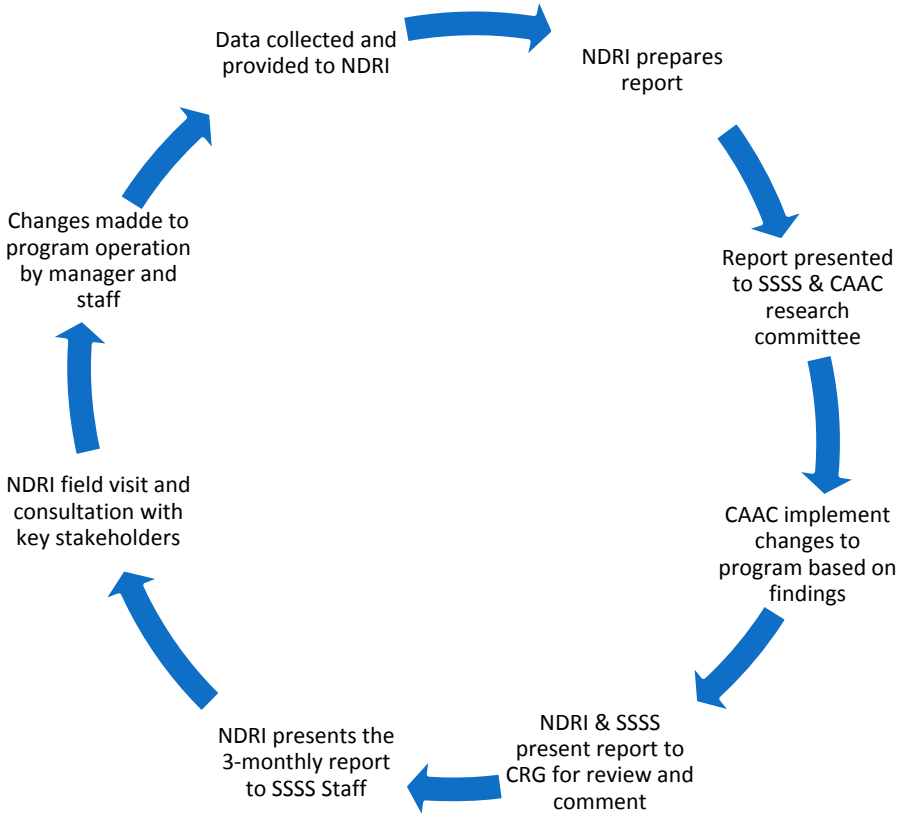
1.3.1 Evaluation process

Every three months the evaluators prepared either a quarterly or a six-monthly (January – March, January – June, July – September, July – December) progress report, based on the indicators outlined in the evaluation framework. The six monthly reports were provided to the NT Department of Health Families, enabling CAAC to meet their contractual obligations.

A participatory action methodology was utilised for the evaluation of SSSS. Figure 1 (page 13) shows the evaluation process. Every three months NDRI prepared a quarterly report, based on SSSS quarterly operational plan data. The data were provided to NDRI one month after the close of the quarter, NDRI then had two to three weeks to prepare the report. The quarterly report was presented to the CAAC internal research committee for review and comment; the evaluators considered all feedback from the committee. Following any changes or amendments, this version of the report was circulated to CRG committee for review and discussion at the quarterly CRG meeting the following week. Any changes as a

result of this meeting were made and circulated within the week. Within a month following the submission of the quarterly report, the evaluator made a two-week field visit to Alice Springs. The field visit was to collect qualitative data related to the report. This included observations of the program in operation and interviews with staff and key stakeholders. A workshop with SSSS staff was also conducted for comment on the report. All of these data were used to inform the six-monthly progress report. As with the quarterly report, this was provided to CAAC internal research committee and CRG for comment. The cycle continues. In November 2011, the ESG requested that any amendments to the reports suggested by the CAAC internal research be tracked and noted. To ensure transparency, two versions of the report were circulated to all ESG members, one with all amendments tracked, and the final version.

Figure 1: *Safe And Sober Support Service* Evaluation Process



1.3.2 Data sources

There were many sources of data used to inform this evaluation. The following is a description of the multiple sources of data used to evaluate the SSSS.

1.3.2.1 Ambulatory case-management

Data to assess the objectives for the ambulatory case-management aspect of SSSS were provided through a number of sources.

Firstly, in order to address the program outputs, outputs were extracted from *Communicare* – CAAC's patient database – every quarter. This data was provided to the evaluators one month following the end of a calendar quarter, and after departmental (Social And Emotional Wellbeing) quarterly operational plan review. In April 2011, it was discovered that the extraction query being used was over-calculating the number of clients by about 20%. In May 2012, it was also discovered that the data on the number of MHCPs for July to December 2011 was incorrect. For the final report, these data were re-extracted and the corrected data are presented in this report.

As part of the program development, processes were implemented to ensure continuity. One process was the redefinition of key terms to provide consistency. For example the definition of an *engaged* client; it was agreed that an engaged client was to be a client with a completed mental health care plan (MHCP). Another change was the way therapy was recorded by therapists. In early 2011, adjustments were made to the *coding of therapy* types by CAAC in consultation with the evaluators. Co-therapy was collapsed into family therapy, as co-therapy was not a type of therapy, rather a therapeutic method; this change affected three records. Motivational interviewing was collapsed into cognitive behavioural therapy, affecting 17 records. This change was made as motivational interviewing was considered by CAAC to be an aspect of cognitive behavioural therapy. *No amendments were made to the client case files or notes, only to the coding of the therapy.* In addition to this, internal procedures were implemented to ensure that therapists only coded one type of therapy per session, rather than multiple therapies per session.

The second source of data were semi-structured interviews with SSSS program staff, conducted at frequent intervals. The interviews were structured around the evaluation framework. Voluntary individual and group interviews with SSSS staff were conducted in September and October 2010, April and June 2011, and November and December 2011.

The third source of data were to address the biomedical indicators. Originally, NDRI were to employ a local research assistant – from one of the AOD services in Alice Springs; however NDRI were unable to fill the position. In February 2012, NDRI contracted a nurse from another CAAC department, to review and collate the non-identifiable data, such as: demographic data; date and source of referral; status of Mental Health Care Plan; biochemical markers for diabetes; biochemical markers for alcohol; K5 scores; and, all AUDIT-C scores. These data were extracted by a file audit of 140 client (89 females and 51 males) files. These clients had more than one AUDIT-C score, or were defined by the SSSS staff as *engaged*; however many did not have MHCPs, so to avoid confusion, these clients will be referred to as *active* clients. The biochemical markers were taken pre and post contact with SSSS. It was agreed where possible, that the measures pre-contact within two years of

referral to SSSS, and the most recent measures since engagement with SSSS. Each measure has been categorised according to available literature, change between scores and categories were documented. Table 4 (page 16) provides a summary of these data.

In addition to this, all AUDIT-C scores for all SSSS clients were extracted from the SSSS. Table 3 (page 15) provides a summary of the number of AUDIT-C scores recorded by client age group. All the AUDIT-C scores recorded were also assessed; there were 544 AUDIT-C measures for 311 individual clients. Of those 311 clients, 110 (35%) had more than one score recorded, the number of AUDIT-C scores ranged between two (51 clients) to 12 scores (one client). Of those with more than one score 72% that had two or three scores. These data are analysed in more detail from page 75.

Table 3: Number of AUDIT-C scores recorded, by count and age group

	15 – 19	18 – 29	30 – 39	40 – 49	50 – 59	60+	Total
1	6	62	61	47	24	7	95
2	1	17	13	15	6	0	38
3	0	3	11	9	5	3	19
4	0	0	8	1	4	0	10
5+	0	1	7	3	0	0	5
Total	7	83	100	75	43	10	311

The fourth source of data were summary reports prepared by AOD workers and therapists following bush trips. Following the development of the evaluation framework, the evaluator created and recommended the use of a template to assist with the reporting and recording of all group sessions. This was implemented for use with the bush trips in mid-2011; and was beneficial as the evaluator was only able to attend and observe one bush trip (December 2011), and it was not appropriate for her to attend the men's bush trips. The summaries of bush trips completed by the SSSS AOD workers and therapists outline the number of participants, activities, and outcomes from each bush trip. This was felt to be more reliable than relying entirely on staff interviews, a small but significant changes are often not recalled during interviews. These were thematically analysed to provide a summary of the activities and participation in the bush trips.

Table 4: Demographic profile of file audit clients (n=140), by gender

		Females N= 89	% of Female	Males N=51	% of Males	Total N=140	% of Total
Age groups	15 – 19	2	2%	2	4%	4	3%
	20 – 29	26	29%	9	18%	35	25%
	30 – 39	31	35%	16	31%	47	34%
	40 +	30	34%	24	47%	54	39%
Referral Source by Sector	AOD Sector	13	15%	7	14%	20	14%
	Community	3	3%	1	2%	4	3%
	Government	0	0%	1	2%	1	1%
	Families	3	3%	2	4%	5	4%
	Health	30	34%	19	37%	49	35%
	Health & families	1	1%	2	4%	3	2%
	Justice	3	3%	6	12%	9	6%
	Self	29	33%	10	20%	39	28%
	Youth	2	2%	1	2%	3	2%
	Other	5	6%	2	4%	7	5%
Number of days by Referral Source (Avg)	AOD Sector	210.2		190.2		200.2	
	Community	335.7		70.0		202.8	
	Government	0		0.0		0	
	Families	511.3		56.0		283.7	
	Health	350.2		419.6		384.9	
	Health & families	138.0		76.0		107.0	
	Justice	105.7		257.3		181.5	
	Self	275.1		306.6		290.8	
	Youth	243.0		237.0		240.0	
	Other	282.0		134.0		208.0	
MHCP	Yes	34	38%	14	27%	48	34%
Diabetic	Yes	19	21%	9	18%	28	20%
Depression	Yes	12	13%	8	16%	20	14%
Pharmacotherapy	Acamprosate	2	2%	0	0%	2	1%
	Naltrexone	3	3%	6	12%	9	6%
	Naltrexone / Acamprosate	0	0%	1	2%	1	1%

Originally, it was expected that the evaluator would conduct interviews with current active clients. Rather than the evaluator making direct contact with clients, and CAAC breaching client confidentiality by sharing information with an outside party without client consent; clients were to be informed about the evaluation and purpose of the interviews by their AOD workers and therapists. If the client was willing to participate and consented, their details were then to be passed on to the evaluator who would then contact them and ask if they were interested and willing to participate in the interview. During the 2011 site visits, the interviews were to be organised; however, the only opportunity for the evaluator to speak to clients, was during the women's bush trips. Interviews were held with six women during the trip; however, there were no other opportunities for the evaluator to speak to the clients, engaged or otherwise.

To address this gap information two other sources of data were sought. Firstly, SSSS staff were asked to provide some case studies about clients that they had assisted. The evaluator provided no framework or structure for the data provided in these case studies. The AOD therapists provided 16 case studies in January 2012, each deciding on the level of detail that they would provide. The case studies provided both an indication of the outcomes for clients, and the work undertaken by the program staff. As some of the case studies included pseudonyms, while other referred to the client by an initial; to ensure anonymity and confidentiality all names were changed, and all other possible identifiers were also removed. The case studies were reviewed and thematically analysed based on the topic of discussion.

The second new source of data was a survey developed and completed by SSSS staff and completed in February 2012. The SSSS staff identified 91 clients that they deemed as currently *active* with SSSS. The teams (therapists and AOD workers) systematically collated their knowledge of these clients, as some of this data are not recorded in *Communicare*. All data provided to the evaluators was non-identifiable. The survey covered demographics and outcomes for clients. These data are presented in Section Clients of Safe and Sober Support Service (page 30).

1.3.2.2 Prison In-reach Program

Data to assess the objectives for the Prison In-reach Program (PIRP) aspect of SSSS were provided through three sources. Firstly, each of the individual service providers provided the number of sessions and participants, at the end of every quarter. These data were provided in different formats directly to the SSSS manager, who then passed them on to the evaluator for the quarterly report. The format of these data were not consistent. For instance; the PIRP does not have a definition of course completion; when detailed attendance data was provided the evaluator defined completion as a participant who attended all sessions. However, some agencies provided summary data, defining completed course participants by their own criteria; in these cases, the evaluator has reported these data as provided by the agency.

The second source of data were reports from the PIRP service providers. As with the group session, after the initial discussions with the service providers, the evaluator suggested the service providers provide more detailed information regard course provision and participation; to assist with this reporting template was developed. The template was not compulsory but provided additional contextual data to assist in the evaluation; however it was not utilised until late 2011, even then not all service providers used it. Those agencies that did not use the template did not provide any additional information.

The third source of data, were semi-structured interviews with managers and course facilitators from each of the service providers. Interviews with service providers were conducted in September and October 2010, June 2011, and November – December 2011. Three attempts, by phone and email, were made to contact all managers and course facilitators, for interviews during each of these evaluation visits; no response was considered as declining to participate in the interview. The interview data were thematically analysed, providing context to the operation of the PIRP.

It should also be noted that the second objective of the PIRP, was not able to be assessed.

1.3.2.3 AOD Sector Support & Engagement

Two objectives for the AOD sector support and engagement aspect of SSSS were assessed through three sources of data. Firstly, quantitative data were extracted from *Communicare* and provided to the evaluators. The second source of data was the minutes from the CRG meetings; these minutes provide an outline of the discussion, and meeting attendance.

The third source of data, were semi-structured interviews with representatives from external agencies and service providers. Due to the diversity of the agencies with which SSSS have contact, and the change of staff in Alice Springs, the SSSS staff identified and provided contact details of individuals with whom they have case managed clients, referred clients to, received clients from, or worked with. These interviews were conducted during the evaluator's site visits in September – October 2010, June 2011, and November – December 2011. Three attempts, by phone and email, were made to contact all identified individuals, and other key staff, for interviews during each of these evaluation visits. A 'no' response was considered as declining to participate in the interview. Most interviews were conducted in person; however, this was not always possible, so telephone interviews were also conducted. It should be noted that interviews were limited to those individuals and agencies with which SSSS collaborated.

1.3.2.4 Program Capacity Building

For the program capacity building aspect of SSSS there are two objectives. There were three sources of data, to assess and evaluate these objectives, and indicators. Firstly, most of these indicators were qualitative, and provided by the SSSS manager. As with the group sessions and the PIRP, the evaluator created and suggested a number of templates to assist

with this data collection, especially if there was a change in senior management. These templates were not used.

The second source of data were minutes from the staff and CRG meetings, these minutes provide an outline of the discussion, and meeting attendance. The third source of data, were semi-structured interviews with SSSS staff. These interviews were conducted during the evaluator's site visits in September–October 2010, April 2011, and November–December 2011. The interviews were with individuals; however, a couple of group interviews were conducted at the request of SSSS staff. The evaluator also observed the program in operation, including attending staff meetings, and a SSSS planning/review workshop in November.

2 Ambulatory Casework Service

2.1 History

The case management aspect of SSSS was based on a pilot program that CAAC initiated and trialled – *GrogMob*[1]. *GrogMob* was one of five pilot projects commissioned by NDRI, to enhance the access of Indigenous Australians to quality treatment for alcohol-related problems. *GrogMob* consisted of two staff members: an Alcohol and Other Drug Therapist with experience in cognitive behavioural therapy and the Aboriginal Liaison Officer/Research Assistant to liaise with client and therapist and provide the social support. The *GrogMob* pilot ran from March 2008 to September 2009, and was evaluated by Peter d'Abbs and Sam Togni[1]. The *GrogMob* positions were re-funded by the Australian Government Department of Health And Ageing in late 2009, for the program to continue. The two positions were integrated into the *Safe and Sober Support Service*. The most recent *Grogmob* AOD therapist became the first SSSS program manager, and though the *Safe and Sober Support Service* is based on the *GrogMob*, there are some distinct differences with *GrogMob* being absorbed into the SSSS.

The core of the SSSS is the ambulatory casework service that consists of three streams of care. A multi-disciplinary team of an Aboriginal AOD worker, a qualified and registered therapist, and general practitioner provide the program services. The overall goal of the SSSS is to:

> *Provide a holistic and culturally appropriate counselling, therapeutic treatment and support service that strengthens the cultural, social and emotional wellbeing of Aboriginal people and their families.*

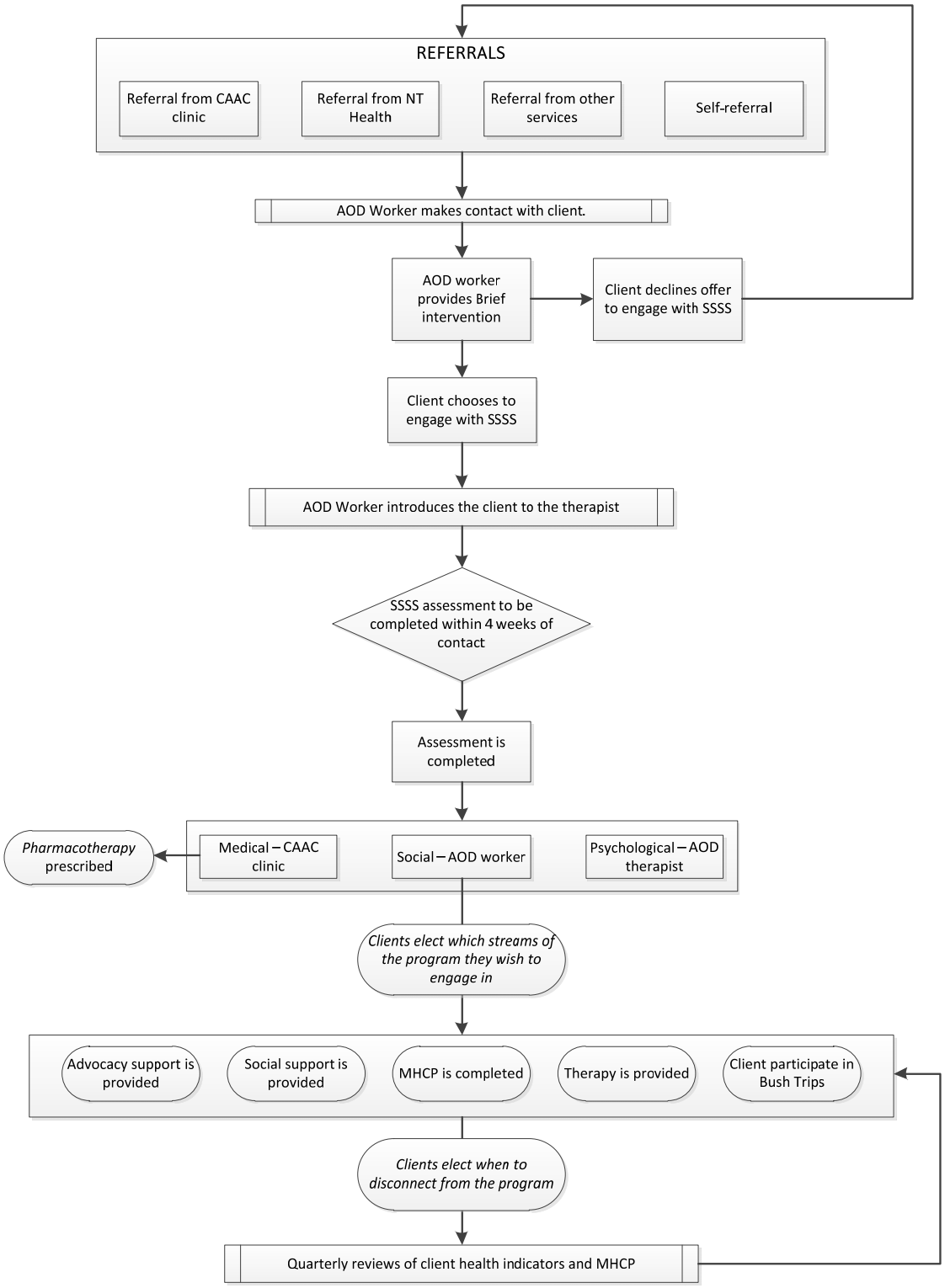
Through the casework service, all clients have access to three streams of care:

- advocacy, social and cultural support;
- structured therapy; and
- medical care, including pharmacotherapy.

2.2 Casework model

The following is a description of each of the client stages in the current model for the SSSS ambulatory case management, as presented in Figure 2 (page 22). The aim of the SSSS is to provide all three streams of care to clients.

Figure 2: *Safe and Sober Support Service*, Ambulatory casework model



2.2.1 Referrals

Clients are referred to the SSSS from numerous agencies and services in Alice Springs. Many people also self-refer to the program as well as *GrogMob* clients who transitioned with the program. The background of each client is different, as are his or her reasons for engaging. When a referral is received, the AOD worker makes three attempts to contact the client. Following staff expressing frustration at the amount of time spent trying to engage clients who were not interested in the program and unwilling to engage; the number of attempts to contact a client was capped at three in late 2010. It must be noted that there were changes to the referral procedures in the March 2011 quarter; inappropriate referrals were excluded, and more information was required from the referrer. Inappropriate referrals are referrals of clients that are not Indigenous, do not have an alcohol issue, or do not reside in the CAAC service area.

When contact is made with a client, the AOD worker will provide a brief intervention, and explain the program to the client. Trust and relationship between the client and the worker are built while support services are provided to clients. In November 2011, procedures regarding the introduction of the therapists to clients, and the completion of the AOD assessment were formalised. These included the completion of an assessment within four weeks of contact, and that *completed assessment* requires *all* three parts of the assessment are completed.

The reasons for referral to SSSS vary as much as the clients, many of which were referred from services and agencies in Alice Springs, such as Community Corrections, as the clients were at high risk of harm. Some clients self-referred, following the success and changes they saw family and friends make. The case studies provided by the therapists provide insight into the reasons that clients have wanted, or needed to engage with the program.

> *Adam was referred to the Safe and Sober team by Community Corrections after an incident of domestic violence where he hit his wife while drinking. Adam was referred to the Safe and Sober team as he was binge drinking at one of the local communities on a regular basis.*
>
> *Matthew and his wife Natalie had been referred to the Safe and Sober team as their binge drinking patterns of alcohol consumption had resulted in domestic violence. The domestic disputes, fuelled by regular binge drinking had eventually resulted in their 2 year old child being removed from their care and placed in the custody of the Department of Children and Families.*
>
> *Barry used to drink with Adam in the creek bed, has been so inspired by Adam's ability to reduce his alcohol intake that he has approached Safe and Sober for assistance in reducing his own binge drinking pattern.*

2.2.2 Engagement

Despite the willingness of clients to participate, the initial engagement of clients with the program was often difficult. Due to the nature of the service and the focus of the program being to work with clients referred to the program, it was necessary to define the clients

according to their degree of involvement with each stream of the program. An engaged client was defined as one who has a completed a Mental Health Care Plan (MHCP) and has therefore agreed to participate in treatment beyond the initial assessment. The completion of the MHCP requires the collaboration and involvement of the AOD worker, therapist, and the medical officer. Despite this definition of engagement, the staff have found that they intensively supported a greater number of clients than just those with MHCPs. According to the SSSS staff, engaged clients were those that they worked with intensively, engaging regularly with the program, and to avoid confusion these clients are referred to as *active* clients.

The case studies provided by the therapist provide an indication of the efforts made by the therapists to engage with the clients, and the time taken for some clients to engage with the program. Often clients are comfortable with the initial engagement for social support, and take time before engaging with therapists. Some clients, are not *ready* to engage at the time they are referred to the program, but some come back at a later date. These clients require a lot of time and effort from the AOD workers and therapists before they engage, many eventually do, just like these clients:

> *Chrissy used to be an aboriginal health worker, but due to many work and family traumas, became heavily addicted to alcohol. Last year I used to ring and then call in on her. A lot of the time I didn't get much response from her and did not feel I was being in any way successful with her. However, we were developing a bond. I didn't hear from her for about three months, then she rang one day and made an appointment to see me.*

> *Esther has been engaged with the Program in an on-again-off-again fashion for at least a year. This woman has chronic health problems, and has needed quite a bit of assistance to get these addressed. Her husband was released from prison at around the same time, and for a while it seemed that all our good work and engagement was going to amount to nothing as they resumed their life of drinking, fighting and homelessness. Esther and her husband Frank made contact occasionally for assistance with social support matters. Over this time Esther has become engaged again as a result of the team working with her and her husband as a unit.*

> *Pauline was supported by her AOD worker for a long time and had always said that she didn't want therapy. She was in CAAAPU and the AOD worker asked me if I could go with her to talk to her about therapy. I went with the AOD worker and explained about therapy, but also talked about difficulties people have in making changes, also some self-disclosure about how when others are around and drinking, it makes it hard to not drink.*

2.2.3 Assessments

AOD assessments are conducted within four weeks of initial contact with the Program. The assessment includes an assessment of each client's: social needs, chronic disease status, and psychological needs. Most of the assessment feeds straight back into a client's MHCP. The assessments are important for the identification of the degree of the client's issues, planning and setting treatment plan, and the collecting of the client's baseline measures. The number of assessments are discussed on page 46.

2.3 Streams of care

2.3.1 Advocacy, social and cultural support

The program provides advocacy, cultural and social support. The cultural support aspect was provided through the provision of both a culturally appropriate and secure service, and a number of activities including bush trips. Clients receive a lot of social support, often well before the assessments and MHCPs are completed. For some clients the social support is all that they are initially willing to engage in. While providing social support the AOD workers and therapists use the time to build relationships and trust with the client. During this time, key information is collated for both the AOD assessment and MHCPs. All staff provide advocacy and social support. The types of social support have been described and defined by the SSSS team. The indicators relating to the support and advocacy stream are discussed from page 47.

Advocacy	coded when SSSS staff act on behalf of clients to access other services and agencies.
AOD support	coded when SSSS staff provide the client with AOD specific support. with have: provided a brief intervention, removed client from a high-risk situation, facilitated admission to residential rehabilitation, provided psycho-education, or organised alternative accommodation.
Brief intervention	coded when information is provided to the client is educating to help reduce.
Cultural support	coded when assistance and support is provided to assist clients to meet their cultural obligations. These include: assistance with funerals, bush trips, safety around payback, sorry business, and bush medicines.
AOD transport	coded when transport is arranged or provided for a client.
Group/community activity	coded when an activity/session run for a number of people. Community activities have included sessions at/ with other agencies.
Social support	coded when the client is provided with assistance to access social services building capacity to negotiate services. Support is provided in the following areas: housing and accommodation, employment, education and training, health and medical, justice and legal sector.
Group therapy	therapists code this when conducting a therapy session for a group. e.g. bush trip.

Some examples of the support and advocacy provided to SSSS clients are outlined in the case studies. Support and advocacy ranged from mentoring, assisting clients with housing applications, assistance with *Centrelink* benefits, and advocacy on behalf of the clients with the NT Department of Children and Families.

> *Adam received a standard capacity building approach from our indigenous staff which included bush trips, mentoring, and social support particularly with various social service agencies. He was provided with some anger management assistance again based on a relapse prevention approach. He was introduced to a vocational specialist, who coordinated an assessment of his physical capacity to do work*

and advocacy work was provided to ensure that the assessor appreciated the progress that Adam had made and that he indeed had some capacity for part-time work which he was interested in doing.

We have assisted Frank with a priority housing application for both of them; and last month, after a long period of deliberation, Esther and Frank mutually decided to enter a residential alcohol treatment program. The Program in question did not allow for husband and wife to be treated simultaneously; Esther and Frank were upset about this, pointing out that they were more likely to succeed if they were both undergoing treatment at the same time, rather than one at a time with the other one 'outside', drinking. This was resolved by them both entering separate facilities on the same day, after a bit of advocacy on the part of the AOD Social Worker.

Kevin was provided assistance initially with receiving Centrelink payments so that he could contribute to the family budget which consisted of his mother's disability allowance. Attention was quickly turned to assisting Kevin to obtain employment which to his credit he was able to do with the help of a vocational consultant who we connected him with and with whom we have a strong professional association with. His transport needs (for work) were addressed through the purchase of a bicycle. Contact is maintained with Kevin and a positive report continues to be maintained and he knows that the SSSS team are happy to see him at the point when he is ready to address of substance abuse issues.

Luke engaged with our service in a reasonably dependent and somewhat detached manner. The focus was initially on assisting him with employment which he showed some initial interest in, but unfortunately despite appropriate work being found he did not avail himself of this. Despite his seemingly lack of progress, SSSS continued to maintain involvement with him and his family and he was provided with assistance with ensuring that he was collecting his medication regularly from the pharmacy. At times, his lack of progress challenged our resolve to continue to provide him with a service but overall engagement was maintained despite his initial lack of progress.

Though some clients disengage following the social support, some have returned later to engage in the other streams of care. For these clients the social support provides them with relief and the opportunity to assess other areas of their lives before they address their issues with alcohol. There is international evidence regarding the value of 'recovery capital'[2], the support and advocacy stream of SSSS is developing and providing clients with the elements essential to achievement of healthier life, and the ability to maintain it in the longer term.

2.3.2 Bush trips

Early in the establishment of the program, when the client to staff ratio was high, the AOD workers started offering weekly day bush trips for clients. One staff member described the women's bush trips, which also applies to the men's bush trips, as opportunities to:

Improve access for the women in the Safe and Sober program and to make them aware, and experience other services and venues. For the female client to know that they have workers and their peers to support them in their goals to give up alcohol and share their stories.

Efforts are made to ensure that the bush trips were offered as consistently as possible; however, weather, sorry business, and illness sometimes prevented the trips from

occurring. When possible the day trips involve taking the clients to bush areas close to Alice Springs; and when that is not possible, the program visits other places around Alice Springs such as the Strelhow Museum. The trips include a barbecue lunch. The most important parts of the bush trips are the opportunity for staff to develop close relationships with clients in a non-threatening environment, and the opportunities for education and group therapy, and occasionally individual therapy.

In addition to the education and therapy opportunities, both the AOD workers and therapists use the bush trips as an opportunity to introduce new clients to the SSSS in a non-threatening way. The bush trips provide a number of benefits, in addition to the therapy. Despite a core group, the participants come from a number of different language and age groups. The groups provide cultural support to peers. When time permits, a different participant selects the destination for the day, where there are: my country talks, sharing of traditional knowledge such as bush medicines and bush foods, a history of country and the families associated with the area.

One of the greatest benefits of the bush trips is that it provides mush needed respite for the clients. In order to attend the clients need to be sober, so for most clients the day trips are a much anticipated weekly (or fortnightly) time away from their everyday lives. More detail regarding the bush trips is provided on page 51.

2.3.3 Structured Therapy

The structured therapy stream of the program was provided by qualified therapists (ideally clinical psychologists), and social workers. As discussed on page 29, the therapists needed to be able to register to claim *Medicare* rebates for the provision of therapy.

Therapy has been provided in the program in a number of forms and settings. In addition to the structured therapy, bush trips were also opportunities for clients to engage in both group and individual therapy. Two therapists also provided structured therapy to women in the ASCC. More recently, the SSSS has developed an art therapy group as part of the program. The following case studies provide an indication of the different therapies and approaches used with clients, many of which were very cautious of therapy and counselling.

> *Donna engaged, but I had great difficulty getting her to explain her story to me, and why she kept doing the same thing. This was finally achieved last week when I used art therapy – not her art but mine to find out her story. She told the story of her drink driving whilst I drew the story. This took the focus off her, reduced her shyness, provided some insight for her and for me into why she constantly does it.*

> *The focus has been on providing Matthew with a relapse prevention approach for managing his anger and alcohol abuse by identifying high risk situations that he needs to manage and establishing appropriate skills for managing difficult situations which he is unable to avoid. Matthew reports a substantial reduction in his alcohol abuse and he appears to be utilising other strategies to manage difficult situations typically concerning emotional regulation. His wife has had a small amount of therapy with the main approach being capacity building and social support.*

Susan's therapy was done using cartoons that she drew showing various situations and what she did, including one picture where she drew herself pouring out her can of beer – into the back yard because she didn't want others to see.

2.3.4 Medical

The medical stream of the program is greater than the prescription of pharmacotherapy and the signing off of MHCPs. The medical stream includes the medical assessment as part of the AOD assessment as well as baseline medical measures for assessment and screening of chronic diseases. The medical officer's role includes the: revision of the MHCP; completion of the Indigenous Adult Health check; assessment and, if appropriate, prescription of pharmacotherapies that assist with alcohol withdrawal; assistance with chronic disease management; and the monitoring of baseline indicators (as discussed from page 55).

The original program plan relied entirely on CAAC clinic for the provision of the medical stream of the program. However, the program staff faced a few issues with getting access to the clinic, and ensuring continuity of care for clients. To address this, between February and June 2011, the program had a part-time medical officer based within the program. The presence of the medical officer improved a number of MHCPs, and had a number of additional benefits. The addition of the SSSS medical officer, and a consulting room in the SSSS offices, was a huge benefit to the program. As discussed in Table 24 (page 67), the number of SSSS clients with MHCPs increased with the inclusion of the medical officer on the program.

The benefits of the medical officer for staff were greater than the completion of MHCPs. According to staff, the medical officer has facilitated the regular use and recording of the AUDIT-C, K5 and chronic disease management by the staff. In addition to this, locating the medical officer in the program also improved the case management of clients. All staff discussed the value of having the medical officer on-site, as they were able to get new clients to see the medical officer early in their contact with the program. Since the resignation of the GP, SSSS have worked closely with the CAAC clinic for the medical stream of the program; however, this is not as effective as having a medical officer on-site.

2.4 Completion and outcomes

There is no defined completion for the program. Every three months the clients are reviewed, this included the taking and recording of key indicators such as AUDIT-C and K5. Clients determined when they wished to disengage from the program, or a particular stream of care. For many clients that 'complete' the program, the intensity of the support is reduced, but they remain active through the participation in bush trips. There was also consideration of expanding the group session to create a specific relapse prevention program. Many of the additional outcomes for clients are difficult to measure as they were not monitored. The case studies provide an indication of some of the outcomes and results for clients, and their families. The outcomes range from reducing alcohol consumption,

gaining accommodation and employment, admission to residential treatment, and regaining custody of children.

> *Luke has found employment and is currently employed and reports that this has had a substantially positive effect on his self-esteem and this in turn is helping him to reduce his binge drinking pattern of alcohol abuse.*
>
> *Olive stopped drinking, has resolved relationship issues, and all children have been returned to her. She's banned family from coming to her house to drink; having put a lock on the gate, but she allows them in for meals and getting together without alcohol.*
>
> *Susan engaged with her aod worker and me and we supported her in making positive changes. She goes to the Learning Centre every day to sew and do other art work, and goes to church and bible studies. She has encouraged her daughters, husband and other family members to become involved with our program.*

2.5 Program Staffing

The multi-disciplinary approach of the SSSS required various staff such as; the program manager, program administration officer, Aboriginal AOD workers, psychologists, clinical psychologists, social workers, and when possible medical officers. The staffing for the SSSS is outlined in more detail in section "Employment and retention of well supported and trained program staff" on page 81; however at full staffing the team consists of a manager, administration officer, a medical officer, and nine pairs of therapists and an AOD worker. One of these pairs is funded by the Australian Government Department of Health and Ageing. Each team member brings different skillsets to the Service. The following is a description of the roles within the SSSS team.

2.5.1 AOD workers

The AOD workers provide support and advocacy for the client. The AOD workers are Aboriginal people, with strong connections to Central Australia. All the AOD workers come with a diverse background and experience, including primary health care, mental health, youth work, and community development; however very few have an AOD-specific background. As part of the NTDHF funding arrangements, all staff working in the AOD sector were required to have completed AOD-specific training to Certificate IV level or higher. This is discussed in further detail in Section: Number and type of AOD training courses offered, and level of participation, page 101. Each AOD worker was paired with an AOD therapist, and when possible the partnerships were based on gender. There was only one male therapist however, thus preventing firm partnerships. The original program design had eight SSSS AOD workers, and a *GrogMob* AOD worker.

The AOD workers role was to visit referred clients to explain the program to them and invite the client to participate. The AOD workers were generally the first point of contact with the program. In some cases it tooka number of attempts to locate and contact clients, and build relationships. Trust and relationships between client and program staff were built through the provision of support and advocacy. The involvement of the AOD

workers in all cases ensured that the clients were receiving a culturally secure and appropriate service. Support and advocacy were provided to the clients in many ways. Some of the support options offered included: support letters, assistance with accommodation, accessing training and employment opportunities, parenting support, and, assistance with *Centrelink*.

2.5.2 AOD therapists

The SSSS therapists have included: AOD counsellors, social workers, psychologists, and clinical psychologists. The therapists develop and build relationships with the clients through the provision of support and advocacy; in addition to this they provide one-on-one and group therapy, counselling, and psycho-education. For much of the program the number of therapists has fluctuated, at one point there was one therapist to three AOD workers.

Clinical psychologists and social workers were the preferred therapists as they are able to claim *Medicare* reimbursements for the provision of therapy under MHCPs. The program has had great difficulty recruiting the social workers and clinical psychologists to the program. The first clinical psychologist was recruited in September 2010; prior to this a number of diploma-qualified counsellors were recruited. As at December 2011, the program had one psychologist, two clinical psychologists, and five social workers.

Social workers were also sought for the program, as during the planning stages of the program the social workers were able to register and claim *Medicare* for therapy prescribed under MHCPs; however recent changes to eligibility has resulted in most of the social workers being ineligible to be registered. Changes to the Medical Benefits Scheme, require social workers to have extensive additional training in mental health to be able to register for *Medicare,* these changes were only introduced in late 2011, and these changes have caused the program to consider the most appropriate staff for the program. Since October 2011, the number of therapists increased to allow for a one-to-one partnership.

2.5.3 General practitioner/ medical officer

The medical stream included the medical assessment as part of the AOD assessment, the prescription of pharmacotherapy to assist with abstinence and the signing off of MHCPs. The medical assessment included baseline medical measures for assessment and screening for chronic diseases. The medical officer reviewed the MHCP, and prescribed structured therapy if necessary. The medical officer also assessed the client's need and suitability for pharmacotherapies that assist with alcohol withdrawal and maintaining sobriety.

The program staff faced a few issues in the provision of the medical stream, as the original program concept was based on the medical stream being provided through the CAAC clinic. From February until June 2011 the program had a part-time medical officer based within the program. The presence of the medical officer improved a number of MHCPs, previously the staff identified the greatest barrier to getting MHCPs written and signed off

by the GP, as there were issues getting timely access to the GPs in the CAAC clinic. The greatest concern raised by the staff was that even if they were able to get an appointment with the clinic, the clients were not able see the same doctor on their next visit – raising issues of continuity of care. The addition of the SSSS medical officer, and a consulting room in the SSSS offices, was a huge benefit to the program. Since the resignation of the GP, SSSS have worked closely with the CAAC clinic for the medical stream of the program.

2.6 Summary

In addition to the ambulatory case management aspect of the *Safe and Sober Support Service,* the program staff were also involved in the Prison In-Reach Program, with the therapists providing the therapeutic interventions to prisoners. As each client is different, and their needs are different, the program model was flexible. There was flexibility for clients, choosing when they wished to engage and whom they engaged with; there were clients that wished to engage only in social support, and those that only wished to engage in structured therapy. There were a number of changes throughout the life of the program; Table 6 (page 34) provides an outline of these events and changes. They are referred to in more detail through the report. The key events include appointment and resignation of program staff, presentation of progress reports, and major or significant changes to the program model.

2.7 Clients of Safe and Sober Support Service

In order to understand the program, and compliment the description of the program, an understanding of who the clients of SSSS were is needed. The demographic data collected in *Communicare* is limited to age and gender; however, the staff survey provides a greater description of the clients, and their needs (as discussed on page 14). A wider profile of all clients, by age and gender, can be viewed in section *Number of client contacts per client, by age and* on page 45. The staff survey provides an indication of clients' needs, and the areas of assistance and support that the program provided for the client. Table 5 (page 30) provides a summary of the demographics of the active clients. Within this cohort, there were 91 clients:

- 58 (64%) are female and 33 (36%) are male;
- ages range from 19 to 65 years of age;
- 48% (55% of females, 36% of males) are aged 26 to 39 years;
- 74% of clients speak more than two languages;
- 15% of clients speak at least four languages;
- 43% of the clients (33% of females, 61% of male) prefer to speak English; and,
- 57% *prefer* to speak a local Aboriginal language.

The following summarises the issues and needs of SSSS active clients. The majority of clients require support and assistance to income assistance, employment, and accommodation. Most address more than just alcohol consumption; many are also addressing legal issues. In summary of the 91 active clients:

- 79% of females and 76% of males rely solely on Centrelink benefits for their income;
- 12% of females and 3% of male (9%) receive Centrelink benefits and are in part-time employment;
- 16% females and 9% of males are on the waitlists for public housing;
- 22% of females and 30% of males live in public housing;
- 36% of females and 18% of males live in town camps;
- 10% of females and 3% of males (8%) are without a permanent address;
- 57% of females, and 36% of males, live with their extended family and an additional 28% of females and 24% of males live with their partner or children;
- 21% of male clients live alone, compared to just 7% female clients;
- 26% of females, and 45% of males (33%) currently have legal issues;
- 54% have a history of criminal offences;
- 48% of men, and 21% of women have committed alcohol-related offences; and
- 17% of females and 45% of males (27%) have been incarcerated at least once.

The reasons for clients engaging with SSSS were varied, 88 (96%) of the active clients identified up to four therapeutic goals. The four top goals were to:

- 100% identified wanting to reduce alcohol consumption;
- 40% (34% of females, 48% of males) identified wanting to gain employment and/or training;
- 35% (36% of females, 33% of males) identified wanting assistance with managing psychological or emotional conditions; and,
- 34% (41% of females, 21% of males) identified wanting assistance with accommodation.

From this summary, it is evident that the role of the SSSS is much greater than just providing clients with therapy and that there are much greater needs that will assist clients to reduce their alcohol consumption and maintain it in the longer term.

Table 5: Demographic profile of active clients (n=91), by gender

	Females (n=58)	% of Females	Males (n=33)	% of Males	% of Total
Age groups					
19 – 25	8	14%	5	15%	14%
26 – 39	32	55%	12	36%	48%
40 +	18	31%	16	48%	37%
Preferred Languages					
English	16	28%	20	61%	40%
English and another language	3	5%	0	0%	3%
At least one Aboriginal language	39	67%	13	39%	57%
Main Source of income					
Full-time employment	3	5%	6	18%	10%
Part-time employment & Centrelink benefit	7	12%	1	3%	9%
Only Centrelink benefit	46	79%	25	76%	78%
Living with					
Live alone	4	7%	7	21%	12%
Children (only)	8	14%	1	3%	10%
Partner (only)	8	14%	7	21%	16%
Family (inc. with partner and/or children)	33	57%	12	36%	49%
Family and/ or friends	2	3%	4	12%	7%
Incarcerated	2	3%	1	3%	3%
Transient	1	2%	0	0%	1%
Living situation					
Drug & alcohol residential treatment	1	2%	2	6%	3%
Hostel	5	9%	2	6%	8%
No fixed address	6	10%	1	3%	8%
Own/ mortgage	1	2%	1	3%	2%
Prison	2	3%	1	3%	3%
Private rent	2	3%	4	12%	7%
Public housing	13	22%	10	30%	25%
Town camp	21	36%	6	18%	30%
With family	6	10%	5	15%	12%
Priority public housing waitlist	4	7%	1	3%	5%
Public housing waitlist	5	9%	2	6%	8%
Currently has legal issues	15	26%	15	45%	33%
History of offences					
Alcohol-related	12	21%	16	48%	31%
Alcohol-related driving	13	22%	9	27%	24%
Domestic violence	13	22%	12	36%	27%

	Females (n=58)	% of Females	Males (n=33)	% of Males	% of Total
Not domestic violence	3	5%	2	6%	5%
Previous incarceration					
Once	3	5%	9	27%	31%
Twice	4	7%	3	9%	8%
More than twice	3	5%	3	9%	7%
Staff notes indicate change in alcohol consumption patterns					
Yes	27	46%	16	48%	47%
Therapeutic goals (up to four each)					
Identified as wanting assistance with:					
Alcohol consumption	58	100%	33	100%	100%
Employment or training	20	34%	16	48%	40%
Managing psychological or emotional conditions	21	36%	11	33%	35%
Accommodation	24	41%	7	21%	34%
Manage or co-manage health condition	15	26%	6	18%	23%
Inter-agency advocacy	9	16%	4	12%	14%
Custody of children (DCF)	9	16%	2	6%	12%
Personal relationships	7	12%	4	12%	12%
Managing violence	3	5%	7	21%	11%
Legal issues	5	9%	1	3%	7%
Extended family	5	9%	0	0%	5%

Table 6: Timeline of key events and staffing changes SSSS (Ambulatory Case-management)

	Staffing changes	**Program events**	**Evaluation**
2010	Year 1		
Jan	Program manager and AOD worker	Program established	
Feb			
Mar			
Apr	Senior female AOD worker appointed; two AOD counsellors appointed; three AOD workers appointed	Service provision started	
May		SMART RECOVERY *Training course organised by ssss.*	
Jun		Due to shortage of therapists, AOD workers and therapists were working independently.	
Jul	Administrative assistant appointed		
Aug	Senior male AOD worker appointed; AOD worker resigns		Evaluators appointed.
Sept	Senior therapist appointed; four AOD workers appointed; two AOD therapists appointed; program manager resigned	The resignation of the program manager required an adjustment to the program. The Senior AOD worker undertook management of the program.	Evaluation site visit (7 week)
Oct	One of the senior AOD workers was appointed as acting manager	Due to the ratio of staff AOD workers and therapists, the model was adjusted with two AOD workers per therapist. *AIMHI training organised by ssss.*	
Nov			
Dec	Male therapist resigns		
2011	Year 2		
Jan	Manager seconded; Second senior therapist appointed	Therapists attend bush trips.	
Feb	Therapist appointed; Medical officer appointed	Inclusion of the medical stream within the program. Program policies and procedures were established, and implemented	First evaluation report submitted (Jul – Dec 10).

Mar		Program orientation package written	
Apr	AOD worker resigned	Program policies and procedures developed and implemented. Women's bush trips reduced to fortnightly. The number of clients was being over counted, issue was addressed.	Evaluation field visit (1 week)
May		Changes made to the procedures for recording therapy.	Jan – Mar quarterly report presented Evaluation site visit (2 week
Jun	First senior therapist resigned; Male therapist promoted to senior therapist; AOD counsellor resigns. Medical officer resigns from CAAC.	Changes made to how Bush trips were recorded.	
Jul	Therapist resigns	Medical stream now provided by CAAC clinic.	
Aug	Therapist resigns; AOD worker on maternity leave; Male AOD worker re-employed	Program down to three therapists, however due to illness and leave, there were periods when no therapists were available.	Jan – Jun 6-monthly report presented.
Sept	Two therapist appointed	SMART RECOVERY *Training course organised by ssss.*	
Oct	Therapist appointed	Program now able to operate as per original model – partnership between AOD worker and therapist.	
Nov	AOD worker appointed	AOD Assessment procedures and processes clarified. Program review andworkshop.	Jul – Sept quarterly report presented Evaluation site visit (1 week)
Dec	AOD therapist resigned		Evaluation site visit (1 week)
2012	Year 3		
Jan			
Feb			Jul – Dec 6-monthly report presented.
Mar		Now two women's bush trips operating.	Interim final report presented.
Apr	AOD therapist resigned		
May			
Jun			

3 Summary of Results

3.1 Ambulatory Casework Service

The SSSS has achieved, or made progress towards, most of the performance indicators. Below is a summary of each performance indicator, further detail and a brief discussion of each result is presented from page 43.

Actively supporting and assisting Aboriginal people in Alice Springs experiencing by alcohol related harms

Number of clients referred to the program, by source

Since January 2010, 755 clients were referred to SSSS; at an average of 33 referrals per month (99 per quarter). Fifteen per cent of the referrals were self-referrals, CAAC clinic and other departments provided 41% of referrals, and 43% came from external agencies.

Number of client contacts per client, by age and gender

In total, SSSS had contact with 1047 (502 females, and 545 males) clients between January 2010 and February 2012; 614 clients were supported in 2010, and 620) in 2011. Most of SSSS clients are female (53%); and are aged 40 years or over (40%). The program had 7800 contacts with clients, each client receiving between seven and eight contacts each.

Number of clients with a completed assessment by the program

A completed assessment includes a social, psychologically and medical assessment of client needs. An average of 34 assessments were completed each quarter from April 2011, the numbers have varied and are dependent on staff availability and access to the medical stream of the program.

Improve the physical, psychological, and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program

Number of treatment sessions for each engaged client, by stream of care

Data specifically regarding the number of treatment session per client by stream of care was not available. Throughout reporting the number of clients and client contacts, by type of support and therapy, and the ratio of contacts aggregated, have been used to respond to this indicator. AOD support, advocacy services, and assistance with transport are the main three types of support and advocacy services clients receive. Overall, each client received an average of seven contacts for support and advocacy.

In total 153 clients engaged in therapy, with between 24 and 41 clients engaging each quarter. The most frequently provided therapies remained the same across all the quarters: cognitive behavioural therapy; supportive psychotherapy; and, interpersonal therapy. The average number of therapeutic interventions ranged between two and six per client.

Number of clients being case managed

As case management is with external agencies, internal case management has been recorded as case discussions and conferences; between January 2010 and February 2012 there were 100 case conferences and 1015 case discussions were recorded.

Thematic analysis of long-term outcomes of engaging clients – alcohol consumption, general wellbeing, housing, health, & employment.

Clients receive intense support from the SSSS AOD workers and therapists. Some of the outcomes are not measureable or fit within the defined performance indicators, such as gaining employment and housing. The outcomes for the SSSS clients vary according to their needs and the 'treatment' that each client has received. Some of the outcomes for clients have included the gaining access to temporary accommodation, employment, enrolling in training courses, and gaining custody of children.

*File audit of clients, for changes in the management of diabetes by clients, through the monitoring of: Cholesterol levels; Blood glucose levels (*HbA1c*); & Blood pressure*

The file audit provided biomedical measures of diabetic indicators: cholesterol, blood glucose level, and blood pressure.

Total cholesterol – Of those with cholesterol measure recorded 55% had pre-contact measures deemed high, while 59% had post-contact measures within normal levels, of the 35 clients with two measures, 57% were within the normal levels following contact with SSSS. Most of those (70%) that had an increased cholesterol measure remained within the normal level, and just two clients had their levels increase to high risk.

Blood glucose measure – Glycated Haemoglobin (HbA1c). Of the 22 clients with HbA1c measures recorded, 20 had diabetes; 18% pre-contact and 19% post-contact were within the normal range, the remaining clients had HbA1c greater than 7.1%. Of the 16 clients with two measures, nine decreased their HbA1c measures; however, 52% of this group maintained high to too high levels.

Blood pressure – Of those 125 with blood pressure measures recorded, 73% had pre-contact and 67% had post-contact measures within normal range. Sixty-six per cent (64% of females, and 70% of males) maintained or lowered their blood pressure within the *normal* range. Twenty-five clients (31%) reduced their blood pressure to within normal levels.

Diabetics: Of the diabetics with cholesterol measures recorded (24), just three (12%) had high cholesterol levels, two of these clients remained high following contact with SSSS; the remaining clients maintained or reduced their cholesterol levels to within the normal range for diabetics. Of the diabetics (20) with HbA1c measures recorded, 80% had two measures recorded. Just three clients (8%) had normal HbA1c levels; however, 56% of clients reduced their HbA1c level. Of the diabetics (22) with two blood pressure measures recorded, 54% of clients reduced their blood pressure, while 36% of diabetic clients had acceptable levels of blood pressure.

There were just 15 (54%) of the 28 diabetics in the file audited cohort with all three measures: 80% maintained or lowered their total cholesterol to within normal levels; 19% maintained or lowered their HbA1c to within normal levels; and 32% maintained or lowered their blood pressure to within normal levels.

File audit of clients for changes in alcohol related biochemical markers such as Gamma GT, ALT and MCV

The alcohol-related biomedical markers (GGT, ALT and MCV) were recorded for some clients, these provide an indicator of liver functioning.

Gamma-glutamyl transferase – Of those 103 with GGT measures recorded, 50% had pre-contact measures and 42% had post-contact measures that were within the normal range, the remaining clients had GGT greater than 60U/L. However, of the 38 clients with two scores documented, 20 (53%) decreased their GGT levels; with 29% retaining or reducing their GGT levels to normal, another 8% of the cohort increased their GGT but remained in the normal range.

Alanine Amino Transferase (ALT) – Of those 101 with ALT measures recorded, 80% were within the normal range, with 20% of the cohort having raised ALT scores. Of the 37 clients with measurable change, 19 decreased their ALT measures; with 40% maintaining or reducing their ALT measures to within normal range. Of the 16 clients with an increased ALT measure, 81% remained within normal levels. Overall following contact with SSSS, just seven clients (20%) had *raised* ALT scores.

Mean Corpuscular Volume (MCV) – Of those with MCV measures recorded 96 (90%) were either high or within the normal range, the remaining clients had MCV less than 80fL. Of the 44 clients with two measures, 13 had a decrease in their MCV measure. The lower an individual's MCV the greater the concern, overall, 90% of clients maintained or changed their MCV to within normal levels. Just three (7%) of clients had MCV levels that were too low.

Enabling clients to manage their mental health issues and reduce their alcohol consumption

Number of clients managed on a mental health care plan (MHCP)

In total, 80 MHCPs were completed, 56 for female clients, and 24 for male clients.

Amount of income generated by the program, from Medicare , and other sources (Courts/ DOJ)

Since January 2011, there were 381 items claimed by the GPs and SSSS therapists. A total of $33,537.45 was claimed and $29,943.45 paid under the MBS. The SSSS therapists claimed $15,681.00 ($12,122.00 paid) for 138 items, and the GPs claimed $17,856.45 ($17,821.45 paid) for 243 items.

File audit of clients, for changes in the management of depression by clients, through the monitoring of: K5 scores

Of the 140 file audited clients, 13% had at least one K5 scores recorded; 73% had pre-contact and 72% had post-contact levels of either high or very highly distressed. The K5 scores ranged between seven to 23, all showed some level of distress, and all of these clients were also diagnosed with depression.

Decrease in the alcohol consumption and a change in drinking patterns of clients

Audit C scores for both engaged and non-engaged clients (including relapse prevention maintenance) over time for all clients with 2 or more scores entered.

The AUDIT-C, though not as sensitive to change as the AUDIT, was used to monitoring or tracking client alcohol consumption. All the AUDIT-C scores recorded were also assessed; there were 544 AUDIT-C measures, for 311 individual clients. Overall, 55% decreased their AUDIT-C scores, 13% maintained their scores, and 32% increased their score. Of those that decreased their AUDIT-C scores 14 (67%) reduced their overall risk.

Of the active clients 9% of the cohort started with an AUDIT-C score of zero (no risk). Of the 78 active clients with two AUDIT-C scores 4% maintained no risk levels of consumption, 60% decreased their AUDIT-C scores; with 50% of these reducing their drinking to no or low risk levels.

Reduction in the levels of alcohol-related events experienced by SSSS clients following contact with the program

It was recommended that this objective, and performance indicator be reconsidered. Many confounding factors and uncontrollable that influence these data, and it is recommended that it not be used.

3.2 Program Capacity Building

The SSSS has increased the capacity of the AOD sector, and continues to do so, through the employment and retention of well-supported and trained program staff, and through the training and education of the program staff. Though recruitment was slow, by December 2011 SSSS had 90% of the full staffing complement. Program procedures were progressively developed and introduced in 2011; this has improved the outcomes and reporting of the program outputs as the staff are clear about what is expected and how to record their activities.

The SSSS have participated in a variety of training courses, including Certificates III and IV in Community Services. The number of completion of the certificate courses has been small; consideration needs to be given to the factors contributing to lower completion rates.

Improve and build capacity of SSSS program staff [internal]

The recruitment of SSSS staff, especially *Medicare* registrable therapists, was slow. As of December 2011, the SSSS required just two AOD therapists and a medical officer.

Employment and retention of well-supported and trained program staff

Development of clear and appropriate program and operational procedures and documents: including referrals, case management, support, and advocacy tools

This indicator was introduced as program procedures and policies were not in place in 2010. During 2011, clear and appropriate procedures were developed and implemented. Ongoing training will be required to ensure that quality data are recorded.

Number and progress of individual CAAC career development plans

This indicator achieved annually, by the SSSS program manager.

Thematic analysis of semi-structured interviews with program staff regarding the use and development of the MHCP/ Stay Strong Care plans

This performance measure was implemented when very few MHCPs had been completed, and staff had a number of barriers preventing the completion. With the implementation of the program procedures and changes that addressed the barriers, the number of completed MHCP increased. A regular review of processes and barriers is required to ensure MHCPs are continue to be completed.

Improve and build capacity of SSSS program staff [internal]

Provision of appropriate training

Number and type of AOD training courses offered, and level of participation

SSSS staff have participated in a variety of training courses, workshops, and conferences. These opportunities included, three groups of SSSS staff attending interstate AOD conferences in 2011 – Australian Winter School, Drug and Alcohol Nurses Association and, Australasian Professional Society on Alcohol & Other Drugs (ASPAD).

Number of AOD workers actively completing certificates II to IV in Community services – Alcohol & Other Drugs

The SSSS staff are required to complete Certificates III and IV in Community Services (Alcohol And Other Drugs); one AOD worker was completed the Certificate III, one AOD worker has completed and seven AOD workers and two therapists were enrolled in Certificate IV in Community Services.

Number of SSSS program staff trained in AOD in self-management and recovery programs

There have been two opportunities for SSSS staff to be trained as SMART RECOVERY facilitators: May 2010 and September 2011. In May 2010, seven of the staff at that time were trained. In September 2011, another seven staff were trained in SMART RECOVERY. SSSS have decided not implement the SMART RECOVERY program, as it is not appropriate for the client group.

Number of SSSS program staff receiving cultural competency up-skilling

This is an original performance indicator. There is no formal cultural competency up-skilling program for SSSS staff; the senior AOD Aboriginal workers provide up-skilling within the SSSS Program. A small number of training sessions on cultural competency for all CAAC SEWB staff, and regular informal guidance to SSSS staff, is provided. The senior therapists also completed a two-day culturally competency training source.

3.3 AOD Sector Support and Engagement

An interagency AOD network has been established, and is operating. Now that SSSS is established, the role of the CRG should be reassessed and reviewed. There is a lot of value in maintaining this interagency network, with amendments to the terms of reference. Potential remains, now that SSSS is established, for the strategic expansion of sector support and engagement.

Establishment of a well-supported interagency AOD network in Alice Springs

Number of clients referred to the program, by source

From January 2010 until December 2011, *755 clients* were referred to the SSSS, by more than 42 different agencies. The number of referrals, averaged 99 per quarter, has ranged from 41 in the first quarter to 147 in July 2010 quarter. Twelve agencies averaged more than one referral per quarter. Fifty-one per cent of referrals have come from the Health and Families sector, 80% of these were from CAAC departments.

Number of case-managed clients across AOD services

The number of clients being case managed by SSSS varied each quarter, with 30 in April 2011, to 19 in October 2011. This fluctuation is most likely a result of changes in data recording.

Participation by AOD sector members in CRG meetings

The terms of reference identify the 15 member agencies of the CRG, including 13 the representatives. Since February 2010, there were 13 CRG meetings. Attendances ranged from one to 11 meetings, the overall average attendance was six meetings.

Establishment of formal collaboration [service] agreements between agencies

This indicator was identified to ensure that interactions with other services were clarified, and purposeful, as in 2010, there were a number of inter-agency collaborations without a clear purpose. These collaborations ended in 2011, since then no formal agreements arranged between SSSS and other services.

Improve and build capacity within wider AOD sector [external]

Number and type of AOD training courses offered, and level of participation

Ssss organised and facilitated three AOD training course for the Alice Springs AOD sector.

3.4 Prison In-reach Program (PIRP)

The PIRP courses commenced in the ASCC in June 2010; following a hiatus between January and June 2011, the PIRP courses recommenced in June 2011. The evaluation of the outcomes and impact of the PIRP was not possible with the available data. Now that the process barriers the PIRP faced in 2010 have been addressed, the outcomes and impact of the PIRP should be comprehensively assessed and reviewed.

Provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre

Number of alcohol rehabilitation program sessions delivered in ASCC and Number of clients engaging in and completing each alcohol rehabilitation program in prison

The PIRP courses commenced in the ASCC in June 2010, following a hiatus between January and June 2011, the PIRP courses recommenced in June 2011. In total 19 courses were provided under the PIRP, with 198 individuals enrolling, and 127 completing all sessions of the courses in which they enrolled.

Number of PIRP clients who contact and engage with SSSS following release from ASCC

This indicator was recommended, but not implemented, following the hiatus of the PIRP; however data has not be collected, or provided for evaluation.

Reduction in the levels of recidivism for prisoners who engage with SSSS

Quantitative analysis of alcohol-related offences and imprisonment rates in Alice Springs/ Central Australia

It was recommended that this objective and performance indicator be reviewed. Many confounding and uncontrollable factors affect and influence the data, it cannot be expected that any changes can be attributed to the PIRP. This indicator has not been assessed.

Number of group self-help sessions with other service providers provided and the number of clients who participate

Since March 2011, the only group sessions that SSSS organised were the bush trips; these were not with external agencies. Prior to that, despite there being group sessions with other agencies, no detailed data were provided.

4 Results: Ambulatory Casework Service

This section of the report will discuss and assess the achievement of the objectives and performance indicators of the ambulatory case-management aspect of the SSSS. The ambulatory case-management has five identified objectives:

- actively supporting and assisting Aboriginal people in Alice Springs experiencing alcohol related harms;
- improve the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program;
- enabling clients to manage their mental health issues and reduce their alcohol consumption;
- decrease in the alcohol consumption and a change in drinking patterns of clients; and,
- reduction in the levels of alcohol-related events experienced by SSSS clients following contact with the program.

4.1 Actively supporting and assisting Aboriginal people in Alice Springs experiencing by alcohol related harms

Performance indicators

The aim to actively support and assist Aboriginal people in Alice Springs experiencing by alcohol related harms, will be indicated by:

- number of clients referred to the program, by source;
- number of client contacts per client, by age and gender; and,
- number of clients with a completed assessment by the program.

4.1.1 Number of clients referred to the program, by source

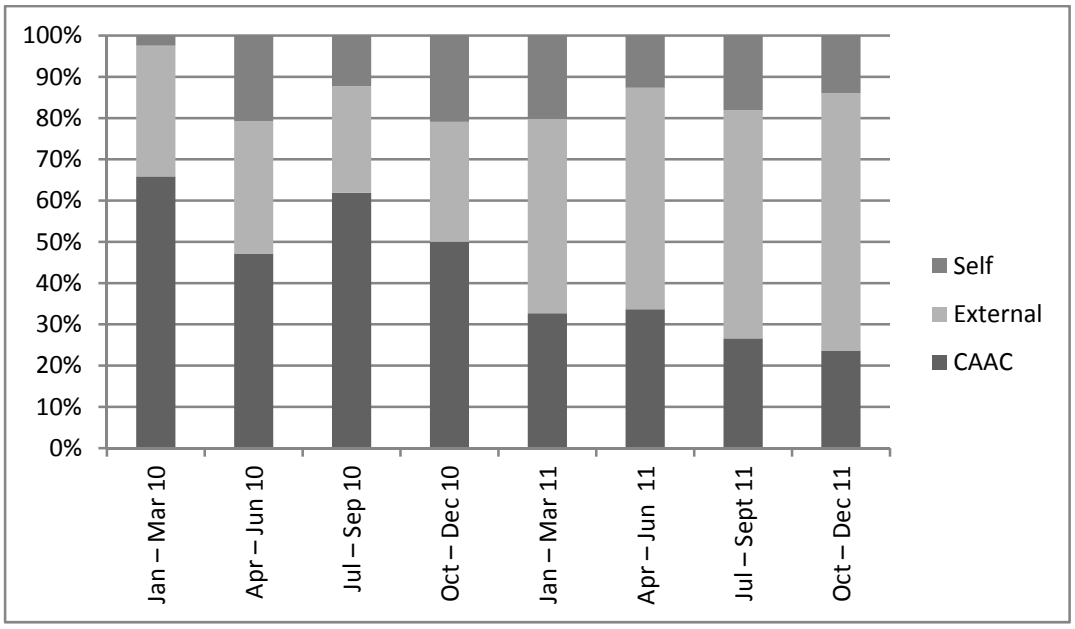
Table 7 (page 44) summarises the number of clients referred to SSSS since January 2010. The referrals by source are presented in more detail in Table 35 (page 94). Since January 2010 quarter, 755 clients were referred to SSSS. The number of referrals peaked in July 2010 quarter with 147. Since October 2010 quarter, there was an average of 33 referrals per month (99 per quarter). It must be noted that changes to the referral procedures in the March 2011 quarter, resulted in a decrease in referrals.

Table 7: Number of clients referred to SSSS by quarter and source type

	CAAC		External		Self		Total
Jan – Mar 10	27		13		1		41
Apr – Jun 10	25		35		11		71
Jul – Sep 10	91		38		18		147
Oct – Dec 10	55		32		23		110
Jan – Mar 11	34		49		21		104
Apr – Jun 11	32		51		12		95
Jul – Sept 11	25		52		17		94
Oct – Dec 11	22		58		13		93
Total	311	(41%)	328	(43%)	116	15%	755

Overall 15% of the referrals were self-referrals; CAAC clinic and other departments provided 41% of referrals; and 43% came from external agencies. Prior to the January 2011 quarter, 61% of the referrals came internally from CAAC departments; this was almost halved as a result of changes to the referral procedures. Figure 3 (page 44) shows the distribution of the referrals for each quarter; most notable is the increasing proportion of referrals from external agencies. External referrals ranged from 26% in July 2010, up to 62% in October 2011. The proportion of self-referrals ranged from 2% in January 2010 up to 21% in October 2010; referrals from CAAC ranged from 24% (October 2011) to 66% in January 2010.

Figure 3: Proportion of referrals by source and quarter



Number of client contacts per client, by age and gender Figure 3 (page 46) and Table 8 (page 45) present the total number of clients by age group and gender, a more detailed presentation of these data are available in Table 39 (page 125). In total SSSS assisted 1047 (502 females, and 545 males) clients from January 2010 until February 2012; 614 clients were supported in 2010 (279 females, and 335 males), and 620 (330 females and 290 males) in 2011. Most of SSSS clients are female (53%); and are aged 40 years or over (40%). The number of clients peaked in July 2010 quarter, this coincided with the commencement of additional staff, as the July 2011 decrease in client numbers also coincided with a change of staff, and decreased availability of therapists.

Table 8: Total number of clients by age group and gender

Quarter	Gender	0–9*	10–14	15–19	20–29	30–39	40+	Total
2010	F	12	5	11	73	84	94	279
	M	10	4	11	98	98	114	335
	Total	22	9	22	171	182	208	614
2011	F	4	6	15	84	104	117	330
	M	7	4	14	56	91	118	290
	Total	11	10	29	140	195	235	620
Jan 2010 – Feb 2012	F	12	10	24	126	155	175	502
	M	13	11	20	132	159	210	545
	Total	25	21	44	258	314	385	1047

The number of clients that the program had contact with (1047) is significantly greater than the number of referred clients for the similar period. This difference in the number of clients is possibly the result of a number factors. There are a number of *GrogMob* clients that have stayed active with SSSS (see page 20). Secondly, it is possible that many clients have not had a source of referral recorded in *Communicare*. These clients are most likely family members of existing clients, and clients that have had limited contact with the program, such as attending a bush trip with a family member, or attending an program at another AOD agency. These clients, and the activities in which they participated have been recorded in *Communicare,* however the source of referral was not recorded. A third possibility is that changes to data recording procedures have resulted in this clients not being counted in the referral process.

Figure 4: Number of clients by gender and quarter

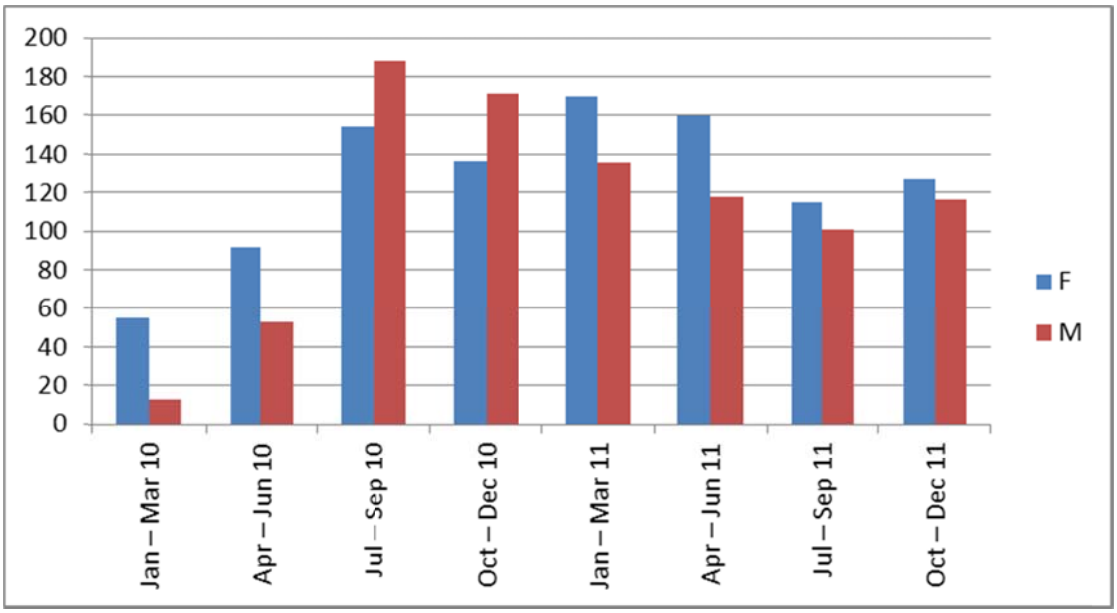


Table 9 (page 46) provides a ratio of the contacts per client from January 2010 to February 2012. By age group, the number of contacts ranged between one and eleven per female clients, and two and six for male clients. Overall, there was an average of seven to eight contacts per client. Overall, female clients receive the greatest level; more than double that of the male clients. Male clients aged 55 and over receive the most support. Female clients between 15 and 54 years have 150% more contacts than the overall average.

Table 9: Total number of clients, contacts and ratio of client contacts per client, by age and gender

		0–9*	10–14	15–54	55+	Total
Females	Clients	12	10	444	36	502
	Encounters	19	54	4805	384	5262
	Ratio	*1.6*	*5.4*	*11.8*	*10.7*	*10.5*
Males	Clients	13	11	478	43	545
	Encounters	34	39	2203	262	2538
	Ratio	*2.6*	*3.6*	*4.6*	*6.1*	*4.7*
Total	Clients	25	21	922	79	1047
	Encounters	53	93	7008	646	7800
	Ratio	*2.1*	*4.4*	*7.6*	*8.2*	*7.4*

4.1.2 Number of clients with a completed assessment by the program

The formal assessment of clients and planning of client treatment is a key part of the program. The formalisation of procedures, including the recording of activities, has shown a vast improvement in the number of clients with a completed assessment, or an ongoing assessment. The assessment of clients provides the basis for directions of both structured

therapy and medical (pharmacotherapy) treatment. Assessments may not be completed in one session. Table 10 (page 47) presents the number of assessments completed since July 2010, since the April 2011 quarter an average of 34 assessments have been completed each quarter. In April 2011, the assessment procedures were implemented as part of the Program, prior to this procedures were not formalised or consistent.

Table 10: Total number of clients, by assessment status

	Assessment Completed On-call	Assessment Completed	Assessment Incomplete	Assessment Ongoing	General Counselling	Therapeutic Intervention with MHCP	Intervention without MHCP
Jul – Sep 10	-	-	-	9	-	-	-
Oct – Dec 10	-	-	1	3	-	-	-
Jan – Mar 11	-	-	2	9	1	-	-
Apr – Jun 11	1	26	-	54	-	-	-
Jul – Sept 11	-	35	18	14	-	6	-
Oct – Dec 11	-	42	43	112	7	36	8

4.2 Improve the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program

Performance indicators

The improvement of the wellbeing of clients, through the provision of alcohol treatment is indicated and measured by:

- number of treatment sessions for each engaged client, by stream of care;
- number of clients being case managed;
- thematic analysis of group work summary reports;
- thematic analysis of long term outcomes of engaging clients – alcohol consumption, general wellbeing, housing, health, & employment;
- file audit of clients, for changes in the management of diabetes by clients, through the monitoring of: cholesterol levels; blood glucose levels (HbA1c); & blood pressure; and,
- file audit of clients for changes in alcohol related biochemical markers such as Gamma GT, ALT and MCV.

4.2.1 Number of treatment sessions for each engaged client, by stream of care

Data specifically regarding the number of treatment session per client by stream of care was not available. Throughout reporting, the number of clients and client contacts by type of support and therapy, and the ratio of clients to contacts, have been used to respond to

this indicator. In order to provide services to improve the physical, psychological, and wellbeing of clients, the program provides a variety of support and advocacy services (Table 11); and, various therapeutic interventions (Table 12 and Table 13.)

Support and advocacy

Table 11 presents the number of clients receiving support and advocacy services. AOD support, advocacy services, and assistance with transport are the main three types of support and advocacy services clients receive. Overall, there was an average of seven contacts per client. The decreases between quarters in 2011 were the result of the way in which activities were coded for consistency across the program. One of the biggest changes was the way in which bush trips were recorded. The types of support and advocacy are defined on page 24.

Table 11: Number of unique clients by type support and advocacy, by quarter

		Advocacy services	Advocacy/ liaison youth	AOD support	Assisted with transport	Brief interventions	Cultural support	Group Therapy	Group/ Community activity	SSSS Social Support	Telephone contact	Youth outreach team visit
Jul – Sep 10	Tot	66	0	164	0	0	16	0	62	0	0	0
Oct – Dec 10	F	34	8	90	54	40	43	0	44	37	11	1
	M	9	6	38	18	20	28	0	21	9	0	0
Jan – Mar 11	F	124	0	144	139	40	47	9	24	0	44	0
	M	59	0	109	40	28	73	45	31	0	6	0
Apr – Jun 11	F	43	0	62	53	40	41	10	10	32	0	1
	M	13	0	47	17	20	29	10	13	22	0	0
Jul – Sep 11	F	49	0	66	48	29	47	5	5	44	0	0
	M	11	0	36	14	20	26	15	11	22	0	0
Oct – Dec 11	F	40	0	56	53	29	44	18	9	45	0	0
	M	7	0	53	18	19	33	6	3	21	0	0
Total	F	290	8	418	347	178	222	42	92	158	55	2
	M	99	6	283	107	107	189	76	79	74	6	0
	Tot	455	14	865	454	285	427	118	233	232	61	2

Therapy

The numbers of clients receiving therapeutic interventions each quarter by gender are presented in Table 12 (page 49). There was a decrease between the January 2011 and April

2011 quarters in the number of clients receiving therapeutic interventions. This decrease is most likely the result of a number of factors. Two of the therapists were on extended leave for significant parts of the April quarter, before both resigning from the Program. Due to the short notice given, most of these clients were handed over to other therapists; however, some clients may not have continued to engage. It was also noted that the departure of one of therapists is likely to have caused a decrease in the number of client contacts by therapy, as this therapist was recording therapeutic interventions differently to other SSSS therapists; including coding a therapeutic contact without seeing the client. The departure of this worker is a factor contributing to the decrease in client contacts for therapeutic intervention.

Table 12: Number of unique clients receiving therapeutic interventions, by quarter and gender

	Female	Male	Total
Jul – Sep 10	5	19	24
Oct – Dec 10	16	15	31
Jan – Mar 11	25	13	38
Apr – Jun 11	19	8	27
Jul – Sept 11	16	12	28
Oct – Dec 11	29	12	41
Total	77	76	153

Table 13 (page 50) presents the number of client contacts for each type of therapeutic intervention for each quarter. The most frequently provided therapies remained the same across the quarters: cognitive behavioural therapy; supportive psychotherapy; and, interpersonal therapy. The average number of therapeutic interventions ranged between two and six per client, males averaged between one and up to six sessions per client, while female clients ranged between two and eight sessions each.

Table 13: Number of client contacts by type of therapeutic intervention, by quarter

	Jul – Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011	Oct – Dec 2011
Cognitive Behaviour Therapy	8	44	86	38	34	109
Family Therapy	12	20	23	3	2	1
Interpersonal Therapy	5	5	27	14	10	5
Mindfulness-Based Therapy	5	3	16	5	0	0
Narrative Therapy	18	20	14	10	0	0
Sand Play Therapy	1	27	25	3	0	0
Supportive Psychotherapy	1	12	43	21	14	10
Total number of therapeutic sessions	50	131	234	94	60	125
Total number of clients	24	31	38	27	28	41
Average number of therapeutic sessions per client	2.1	4.2	6.2	3.5	2.1	3.0

Medical

An indication of the level of engagement in the medical stream is provided through data reported under other indicators:

- Number of clients with a completed assessment by the program (page 46);
- File audit of clients, for changes in the management of diabetes by clients, through the monitoring of: Cholesterol levels; Blood glucose levels (HbA1c); & Blood pressure (page 55);
- File audit of clients for changes in alcohol related biochemical markers such as GGT, ALT and MCV (page 61);
- Number of clients managed on a Mental Health Care Plan (page 66); and,
- Amount of income generated by the program, from Medicare, and other sources (Courts/ DOJ) (page 67).

The results of these indicators reflect the difficulty the program has had to engage the medical stream of the program. The program benefited from the placement of the medical officer within the program, however prior to that and following those few months, the program had difficulty engaging with the CAAC clinic.

Bush trips

The bush trips are part of the support and advocacy stream of the program, however they have evolved into opportunities for engagement and group therapy. The recording and coding of bush trips was changed part way through April 2011 quarter. From discussions with SSSS staff it became clear that bush trips were inconsistently multi-coded, with a combination of: cultural support, bush trips (therapy), group/ community activity, sometimes AOD support and brief interventions were also coded. Since May 2011, the

bush trips are identified as group therapy when a therapist attends. The nature of the bush trips means that those clients participating in the trips are supporting each other culturally and socially, as well as receiving group therapy. The bush trips are also opportunities for the therapist to develop relationships with individual clients that may eventually lead to individual therapy. These changes were fully implemented as of July 2011, with related data summarised in Table 14 (page 51). Further information about the bush trips is discussed from page 51.

Table 14: Summary of bush trips, July – December 2011

	July – September		October – December	
	Female	Male	Female	Male
Number of bush trips	4	11	6	7
Number of clients	20	21	43	30
Number of contacts	257		310	

4.2.2 Thematic analysis of group work summary reports

Early in the establishment of the program, it was expected that SSSS would provide group self-help sessions with other service providers. No self-help groups were provided, however some education and support were provided to other service providers. These group sessions varied in purpose and target group. To assess and report on the group work sessions the evaluator suggested the use of the group work summary reports.

The only regular group sessions provided by SSSS were weekly men's and women's bush trips. Early in the establishment of the program, when the client to staff ratio was high, the AOD workers started offering weekly day bush trips for clients. A description of the bush trips has been provided on page 25. As mentioned the bush trips are opportunities to introduce clients to the program, and staff, and develop a wider social support network.

Women's bush trips

In the beginning, only the female AOD workers attended the bush trips; however, with the increasing staff numbers, including therapists, all female program staff attended the bush trips on a rotational basis. Another change in 2011 saw trips reduced from weekly to fortnightly events to accommodate staff workloads. A core group of women attended the day trips regularly; since July 2011 between two and fifteen women attend the trips.

The women's trips have provided education, cultural support, and therapy. The women's bush trips have had therapists regularly attending since late 2010. As there is a core group attending regularly, the therapists try to change the session each week. The therapists provide psych-education on different alcohol-related topics. Some examples of the sessions have included discussion about the physical, social, and emotional damage

excessive alcohol can do. One of the sessions focussed on the cycle of behavioural change; a number of the clients mentioned this during the following bush trip. One of the therapists described the session:

> *Education was provided around the various stages (of change). Discussed with ladies where they saw themselves on the cycle this fortnight, with most ladies being able to name which stage they were currently in. Clients demonstrated this by placing coming forward individually and placing a stone on the cycle of change. They were given the opportunity to discuss why they felt they were at that stage and what it meant for them.*

Other sessions have included the effects and causes of foetal alcohol syndrome, using props such as the FASD dolls, and 'beer goggles' – glasses that simulate the visual effects of intoxication. Opportunities were also taken for group self-help and cognitive behavioural therapy. One of the therapists described one such session:

> *Introduced to the concept that when we have a goal, it is our thinking or unhelpful thoughts/ "rules" that can stop us achieving what we need to. A group member volunteered her story and how she has changed her thinking and made a new "rule" such as "I never drink on a Tuesday because I like coming to the bush trip on a Wednesday". She further stated that she stood up to a male family member on Tuesday night by telling him no to grog, and although he was shocked, he walked away. (We) discussed the concept of being the strong person in your family or finding the strong person who does not drink and spending time with them. Some (of the) ladies could name a strong person in their family.*

The day trips provide opportunities for informal discussion about client needs, including the development of a plan of action for the coming week. The discussions often lead to the opportunities for the women to share their stories; this in turn provided others with the skills to deal with their own situations. One of the female program staff described how a client shared her story:

> *One of the ladies who came on the bush trip does not drink at all but used to be a drinker. She helps her sister and family. This lady shared her own story about alcohol with the other women. The participants enjoyed this session. The woman offered information to the AOD workers as to how AOD workers could assist to educate people to cut down or give up drinking.*

Another staff member described a specific opportunity to share and the benefits this had:

> *It was stated that by discussing where everyone was at with the cycle of change, there was opportunity to draw inspiration, strength, and support from those that are at a different place on their journey. There was also discussion of strengthening support as they meet people they haven't known before and can talk to them through the weeks between bush trips.*

Men's bush trips

The men's bush trips were provided weekly, when possible. A male therapist attended the men's bush trip until he resigned in December 2010. A second male therapist was not employed until May 2011. Since July 2011, participants ranged from one to eight each week. The men's trips provide cultural support, self-help, education, and therapy, with the

primary focus being on group support. Some of the men who attended the day trips have given up alcohol, while others were trying to reduce and manage their consumption.

The sessions provided ways to address relapse prevention, and strategies to maintain goals. As one of the AOD workers is a qualified health worker, there was an increased focus on the wider health and wellbeing of the clients. Some of the sessions included discussions about men's health, including monitoring sugar levels and blood pressure. Other discussions included the recovery process and a discussion of the options available for treatment of alcohol issues. When groups were small, the sessions focused on providing support for the individuals. During one such session, some of the clients requested assistance with employment and their resumes. During one self-help focused session, clients discussed their drinking patterns, leading to a session about skills to reduce harm associated with alcohol use. While another led to talking about the triggers and barriers with plans made to address some of these barriers.

As well as providing support to each other, the men's group also resulted in a number of clients accessing training opportunities, employment, and housing. Primarily the group provided peer-support for men who were aiming to address their alcohol issues. In addition to the education and therapy opportunities, both the AOD workers and therapists used the bush trips as an opportunity to introduce new clients to the SSSS in a non-threatening way. The bush trips provided a number of benefits, in addition to the therapy. Despite a core group, the participants come from a number of different language and age groups. The groups provided cultural support to peers. When time permits, a different participant selects the destination for the day and while there: my country talks, sharing of traditional knowledge such as bush medicines and bush foods, a history of country and the families associated with the area are discussed. One of the greatest benefits of the bush trips is that it provides mush needed respite for the clients. In order to attend the clients need to be sober, so for most clients the day trips are a much anticipated weekly (or fortnightly) time away from their everyday lives.

4.2.3 Number of clients being case managed

This indicator is duplicated (page 96). It was expected to provide an indication of the case management that occurs within the program – between the AOD workers, therapists and the senior team. The recording of internal case management however is coded as case discussions and case conferences, and is of little value to the overall evaluation as it has been not been consistently recorded in *Communicare* by staff. Case discussions and conferences occur regularly within the context of the program. The evaluators propose that this indicator is deleted, and external case management is the reportable indicator. Between January 2010 and February 2012, 100 case conferences and 1015 case discussions were recorded (Number of case managed clients across AOD services, page 96).

4.2.4 Thematic analysis of long-term outcomes of engaging clients – alcohol consumption, general wellbeing, housing, health, & employment.

The original source of information regarding the long-term outcomes for clients was to be the interviews with clients. As these were not conducted; other sources of information have been used, as described in Data Sources on page 13. The staff were asked to provide case studies of clients that they have assisted in the Program, these case studies have then been analysed to provide a snapshot of some of the additional outcomes for clients working with SSSS. All names have been changed. Clients received intense support from the SSSS AOD workers and therapists. As discussed previously (page 30), many of the clients identified goals or areas they wished to change or areas they required assistance with, these included:

- reduction of alcohol consumption;
- gaining employment or training;
- advocacy with other agencies:
- assistance in managing psychological or emotional conditions;
- gaining accommodation; and
- access to *Centrelink* entitlements.

Most of these indicators do not fit or are not measureable within the defined performance indicators; however, these outcomes are catalysts for the longer-term outcomes and maintenance of controlled drinking, or abstinence. The following case studies are the stories of clients from the past year. Some clients chose to engage with SSSS for more of their advocacy and support. These clients sought assistance with accessing the elements necessary to sustain and maintain a healthier life, these included accommodation, employment and training. For some clients, they chose to engage with SSSS to get assistance in access residential treatment services.

> *Gertrude's case goal was to remain sober and achieve safe accommodation.*
>
> *Hilda's major case goal has been to gain access into an Indigenous-specific residential treatment program in Darwin, Council for Aboriginal Alcohol Program Services (CAAPS). Hilda has now been accepted [for residential treatment] after a lengthy assessment interview. She managed to gain a loan from Centrelink for her airfares, and although she has had to cancel her flights due to sorry business. She is still keen to attend this program as she has realised that Alice Springs cannot provide her with the support and safety needed to remain sober.*

For some clients, the support that has been provided has led to clients engaging in training courses, education, and gaining employment. A positive outcome for a number of clients has been that when they were made redundant, a factor that may have caused a relapse, they have gained further employment.

> *Adam was introduced to a vocational specialist, who coordinated an assessment of his physical capacity to do work and advocacy work was provided to ensure that the assessor appreciated the progress that Adam had made and that he indeed had some capacity for part-time work which he was interested in doing.*

> *…Assisting Kevin to obtain employment which to his credit he was able to do with the help of a vocational consultant …His transport needs (for work) were addressed through the purchase of a bicycle.*
>
> *Initial work with Matthew was to help him find employment as he identified this has been a central problem for him and one of the largest precursors to his binge drinking behaviour as he attempted to cope with the boredom ... To his credit he found employment and when he was made redundant he quite quickly was able to find another job and has been in stable employment for the last four months or so.*
>
> *June has had a lot of support from both her AOD worker and therapist…The training provider also provides mentoring and support, including daily transport, emotional support, food (breakfast and lunch) and ongoing negotiation with employment providers…June has completed her business retail course through IAD and is now completing her work placement in order to begin formal employment.*

As identified in section Clients of Safe and Sober Support Service (page 30) there is a large need for accommodation by the SSSS clients as more than a quarter of clients are without permanent accommodation. The gaining of accommodation is a positive outcome for many clients, while for others it is a catalyst for other outcomes.

> *Gertrude completed the final stage of the process herself (with her husband) and is now accommodated at Aherlkeme Village. We will now be working towards completing her transitional case-management plan.*
>
> *June has achieved her identified case management goals: to give up alcohol; live in her own safe accommodation; to complete course; gain employment; son to be enrolled in boarding school. June is now living in safe accommodation which is case managed by Aherlkeme Village. She does not feel pressurised around drinking, has clearly stated that when she is working she does not drink as she prioritizes her work commitments and feels safe.*

The outcomes for SSSS clients vary according to their needs; and the needs of the clients of SSSS are diverse and complex. For most of the active clients, their lives are at crisis, addressing the level of their alcohol consumption might be the primary goal; however, other factors such as housing, employment, and income are often their first priority and necessary for maintenance in the longer term. Further to this the capacity of clients to address these needs independently, is presently not measured or evaluated by the program. The capacity developed in clients, through support and therapy that enables them to address their needs, advocate for themselves, and deal with crises.

4.2.5 File audit of clients, for changes in the management of diabetes by clients, through the monitoring of: Cholesterol levels; Blood glucose levels (HbA1c); & Blood pressure

As described in the Data Sources section (page 13) a file audit of active clients was conducted of 140 clients. Though there were 140 clients in the cohort, not all had all biomedical measures recorded, and the number varied according to the measure. Some clients had just one measure recorded, as presented in Table 15 (page 56), making comparison, and tracking of change not possible for all clients. These biomedical measures (Total Cholesterol, HbA1c, and Blood pressure) were identified to specifically monitor diabetes management, therefore clients with diabetes were specifically reviewed.

Table 15: Summary of the number of biomedical measures recorded in the file audit

		Females N= 89	% of female	Males N=51	% of males	Total N=140	% of total
Total Cholesterol	One	42	47%	21	41%	63	45%
	Two	22	25%	13	25%	35	25%
HbA1c	One	4	4%	2	4%	6	4%
	Two	12	13%	4	8%	16	11%
Blood pressure	One	28	31%	17	33%	45	32%
	Two	53	60%	27	53%	80	57%

Total Cholesterol

As presented in Table 15 (page 56), 70% (72% of females, 66% of males) of the cohort had at least one cholesterol measure recorded. Each *Total cholesterol* score was categorised according levels as the categories used by CAAC clinic: normal range (0–4.0 mmol/L), normal for diabetics (0–5.5mmol/L), high risk (>4.1mmol/L), and high risk for diabetics (>5.6mmol/L). The change in total cholesterol score and categories were assessed.

Table 16: Cholesterol measures (n=98)

Level of risk	Pre measures N=94	% of total	Post measures N=39	% of total
Normal	21	22%	11	28%
Normal diabetic	21	22%	12	31%
High	49	52%	13	33%
High Diabetic	3	3%	3	7%

	Females N=22	% of female	Males N=13	% of males	Total N=35	% of total
No Change (Normal)	1	4%	1	8%	2	6%
Decrease	5	23%	6	46%	11	31%
Decrease (Diabetic)	7	32%	2	15%	9	26%
Increase	9	41%	4	31%	13	37%
Increase (Diabetic)	4	18%	2	15%	6	17%

	Diabetics	Non-diabetics	Overall
Range pre-engagement	2.4 – 7.0	2.6 – 7.7	2.4 – 7.7
Mean pre-engagement	4.6	4.8	4.7
Range post-engagement	2.8 – 7.4	2.3 – 6.1	2.3 – 7.4
Mean post-engagement	4.9	4.4	4.6

Table 16 (page 57) presents the level of risk for each clients and the change in total cholesterol scores before and after contact with SSSS. For female clients with one measure, the pre-engagement measures ranged between 2.6 and 7.6mmol/L, with an average of 4.6mmol/L; the post-engagement measures ranged from 3.1 to 4.6mmol/L, with a mean of 3.8mmol/L. For male clients with one measure: the pre-engagement measures ranged

between 2.4 and 7.7mmol/L with an average of 5.1mmol/L, post-engagement measures ranged from 3.7 to 4.8mmol/L, with an average of 4.25mmol/L.

Two clients with no change in their cholesterol levels, and were within normal range. Of the 20 clients that decreased their cholesterol levels, the average decrease was 0.76mmol/L for females and 0.26mmol/L for males; just two clients remained either high risk or extremely high risk. Thirty-seven per cent of the cohort had increased cholesterol scores, the scores ranged from 3.5 to 7.4 mmol/L. There was an average increase of 0.80mmol/L for females, and 0.87mmol/L for males.

Of those with cholesterol measure recorded 55% had pre-contact measures deemed high, while 59% had post-contact measures within normal levels, of the 35 clients with two measures, 57% were within the normal levels following contact with SSSS. Most of those (77%) that had an increased cholesterol measure remained within the normal level, and just two clients had their levels increase to high risk.

Of the diabetics with cholesterol measures recorded (24), just three (12%) had high cholesterol levels, two of these clients remained high following contact with SSSS; the remaining clients maintained or reduced their cholesterol levels to within the normal range for diabetics.

Glycated Haemoglobin (HbA1c)

Glycated Haemoglobin (HbA1c) is a measure used in diabetes control. As presented in Table 15 (page 56), just 15% (17% of females, 12% of males) of the cohort had an HbA1c measure recorded. Each score was categorised according levels as the categories used by CAAC clinic: normal (<7%); elevated (7.0–7.9%); high (8.0–9.9%); and, very high (>10%). Both the change in level of risk and pre/post engagement scores were assessed. Table 17 (page 58) presents the level of risk for each client and the change in HbA1c measures before and after contact with SSSS. Of the 22 clients with HbA1c measures recorded, 20 had diabetes. Of those 22 with HbA1c measures recorded, 18% pre-contact and 19% post-contact were within the normal range, the remaining clients had HbA1c greater than 7.1%.

For female clients with one measure, the pre-engagement measures ranged from 5.9–13.1% with a mean of 10.3%. For male clients with one measure, the pre-engagement measures ranged from 5.6% to 7.1% with a mean of 6.35%.

Female clients with two measures recorded, had pre-engagement measures of HbA1c ranging between 7.6% and 13.8%, and an average of 10.5%; post-engagement measures of HbA1c ranging between 7.7% and 13% with an average of 9.9%. For male clients with two measures recorded, had pre-engagement measures of HbA1c 4.2% and 7.2%, with a mean of 6.3%; and post-engagement measures of HbA1c ranging between 4.9% and 9.8%, with a mean of 6.8%.

Table 17: Glycated Haemoglobin (HbA1c) (n=22)

Level of risk	Pre measures N=22	% of total	Post measures N=16	% of total
Normal	4	18%	3	19%
Elevated	5	23%	2	12%
High	4	18%	5	31%
Very high	9	41%	6	38%

	Females N=12	% of female	Males N=4	% of males	Total N=16	% of total
Decrease (diabetics)	7	58%	2	50%	9	56%
Increase (diabetics)	5	42%	2	50%	7	44%

	Diabetics	Non-diabetics	Overall
Range pre-engagement	4.2 – 13.8	5.6 – 13.1	4.2 – 13.8
Mean pre-engagement	9.3	9.4	9.3
Range post-engagement	4.9 – 13.0	NA	4.9 – 13.0
Mean post-engagement	9.1	NA	9.1

Overall, there was a decrease of 0.6% in the HbA1c for females, and an increase of 0.4% for males. Of the 16 clients with two measures, nine decreased their HbA1c measures; the average decrease was 2% for females, and 0.75% for males. Of the nine clients with an increased HbA1c measure, the average increase was 1.5% for females, and 1.6% for males. All except one, of this group had HbA1c measures that were above the acceptable levels.

Of the diabetics (20) with HbA1c measures recorded, 80% had two measures recorded. Just three clients (8%) had normal HbA1c levels; however, 56% of clients reduced their HbA1c level.

Blood pressure

Firstly, it should be noted that the reliability of the blood pressure measures is unreliable, especially given some of the apparatus used. There were 125 clients in the file audit cohort that had at least one blood pressure measurement recorded. As presented in Table 15 (page 56), 89% (91% of females, 86% of males) of the cohort had at least one blood pressure measure recorded. To simplify these data, high blood pressure for non-diabetics was categorised as above 140/90mmHg, while high for diabetics were defined as above 130/80mmHg, anything below these levels were defined as normal. Table 18 (page 60) presents the level of risk for each client and the change in total blood pressure before and after contact with SSSS. Of those 125 with blood pressure measures recorded, 73% (6% were diabetic) had pre-contact and 67% (10% were diabetic) had post-contact measures within normal range.

For female clients with one measure, the pre-engagement blood pressure measures ranged from 90–145/ 51–90 mmHg, with an average of 113/72 mmHg. For male clients with one

measure the pre-engagement measures ranged from 100–144/ 66–93 mmHg, with a mean of 122/80mmHg. For male clients with one measure post-engagement, blood pressure ranged from 125–129/77–88 mmHg, with a mean of 127/82mmHg.

Female clients with two measures recorded, had pre-engagement measures of blood pressure ranging between 90–145/60–130 mmHg with an average of 122/80 mmHg; post-engagement measures of blood pressure ranging between 94–174/60–105 mmHg with a mean of 128/81mmHg. For male clients with two measures recorded, had pre-engagement measures of blood pressure 106–164/60–100 mmHg, with a mean of 128/81mmHg; and post-engagement of blood pressure ranging between 100–174/50–103mmHg, with a mean of 127/81 mmHg.

Sixty-six per cent (64% of females, and 70% of males) maintained or lowered their blood pressure within the *normal* range. Twenty-five clients (31%) reduced their blood pressure to within normal levels. Of the diabetics (22) with two blood pressure measures recorded, 54% of clients reduced their blood pressure, while 36% of diabetic clients had acceptable levels of blood pressure.

Table 18: Blood pressure (n=125)

Level of risk	Pre measures N=123	% of total	Post measures N=82	% of total
Normal	83	67%	47	57%
Normal (diabetic)	7	6%	8	10%
High	15	12%	13	16%
High (diabetic)	18	15%	14	17%

Change	Females N=53	*% of female*	Males N=27	*% of males*	Total N=80	*% of total*
Normal	25	*47*	12	*44*	37	*46*
Normal (Diabetics)	4	*8*	1	*4*	5	*6*
High to Normal	4	*8*	4	*15*	8	*10*
High to Normal (Diabetics)	1	*2*	2	*7*	3	*4*
Normal to High	4	*8*	4	*15*	8	*10*
Normal to High (Diabetics)	1	*2*	0	*0*	1	*1*
High	3	*6*	2	*7*	5	*6*
High (Diabetics)	11	*21*	2	*7*	13	*16*

	Diabetics	Non-diabetics	Overall
Minimum pre-engagement	100/70	90/51	
Maximum pre-engagement	199/129	185/130	
Mean pre-engagement	138/86	121/ 77	124/79
Minimum post-engagement	94/50	163/130	
Maximum post-engagement	104/65	174/105	
Mean post-engagement	139/84	123/81	128/82

File audit diabetics

Table 16 – Table 18 summarise the change in the total cholesterol, HbA1c, and blood pressure for the file audited clients, within this cohort there were just 15 (54%) of the 28 diabetics in the file audited cohort with all three measures. In summary, diabetic clients that were part of the file audit showed the following changes:

- 80% maintained or lowered their total cholesterol to within normal levels;
- 60% decreased their total cholesterol between the two measures;
- 19% maintained or lowered their HbA1c to within normal levels;
- 56% decreased their HbA1c between the two measures;
- 36% maintained or lowered their blood pressure to within normal levels; and
- 59% decreased their blood pressure between the two measures.

Of the 15 diabetics with all three indicators recorded, the cohort had normal post-engagement measures for: cholesterol levels (80%); HbA1c (20%), and blood pressure

(27%). Thirty per cent had a decrease across all three measures; 27% decrease two measures; and 13% decreased just one measure. Just one client had normal levels of all three measures after contact with the SSSS program. The majority of diabetic clients had a decrease in all three measures cholesterol (60%), HbA1c (53%) and blood pressure (53%).

4.2.6 File audit of clients for changes in alcohol related biochemical markers such as GGT, ALT and MCV

In addition to diabetic medical markers, the file audit also collated the alcohol-related biomedical markers of Gamma-glutamyl transferase (GGT), Alanine Amino Transferase (ALT), and Mean Corpuscular Volume (MCV), a summary of the number of these measures is collated in Table 19 (page 61).

Table 19: Summary of the number of alcohol-related biomedical measures

		Females N= 89	% of female	Males N=51	% of males	Total N=140	% of total
GGT	One	41	46%	24	47%	65	46%
	Two	26	29%	12	24%	38	27%
ALT	One	41	46%	23	45%	64	46%
	Two	25	28%	12	24%	37	26%
MCV	One	42	47%	21	41%	63	45%
	Two	31	35%	13	25%	44	31%

Gamma-glutamyl transferase GGT

Gamma-glutamyl transferase (GGT) is a test to measure the level of the enzyme GGT in the blood, providing an indication of the level of liver function and alcohol intake.[3] The normal range is 0 to 60IU/L, thus any measure greater than this was defined as having elevated or high GGT. There were 103 (73%) clients in the file audit cohort with at least one GGT measure recorded in *Communicare,* as presented in Table 19. Of those 103 with GGT measures recorded, 50% had pre-contact measures and 42% had post-contact measures that were within the normal range, the remaining clients had GGT greater than 60U/L.

For female clients with one measure, the pre-engagement GGT measures ranged between 13 and 175U/L with a mean of 49.5 U/L. For male clients with one GGT measure, the pre-engagement measures ranged between 23 and 121U/L, with an average of 60.9U/L; the post-engagement measures for males with just one GGT measure recorded, ranged between 38 and 474U/L with an average of 98.6U/L.

Female clients with two measures recorded, had pre-engagement measures of GGT ranging between 20 and 245U/L with an average of 90U/L; and post-engagement measures of GGT ranged between 12 and 455 U/L with a mean of 98.6 U/L. For male clients with two GGT measures recorded, had pre-engagement measures between 24 and 388U/L, with a

mean of 107.2U/L; and post-engagement measures of GGT ranged between 20 and 428 U/L, with a mean of 98 U/L.

Table 20: Gamma-glutamyl Transferase (n=38)

Level of risk	Pre measures N=93	% of total	Post measures N=48	% of total
Normal	47	50%	20	42%
High	46	50%	28	58%

	Females N=26	*% of female*	Males N=12	*% of males*	Total N=38	*% of total*
Decrease						
Normal	5	*19%*	3	*25%*	8	*21%*
High	7	*27%*	2	*17%*	9	*24%*
High to Normal	1	*4%*	2	*17%*	3	*8%*
Increase						
Normal	2	*8%*	1	*8%*	3	*8%*
High	7	*27%*	1	*8%*	8	*21%*
Normal to High	4	*15%*	3	*25%*	7	*18%*

	Female	Male	Overall
Range pre-engagement	13 – 245	23 – 388	13 – 388
Mean pre-engagement	79.1	92.2	83.5
Range post-engagement	12 – 455	20 – 474	12 – 474
Mean post-engagement	98.6	113.3	103.8

Overall, GGT measures increased by 4.7U/L; the average change for the females was an increase of 13.7U/L, while males had an average decrease of 14U/L. For those with a decreased GGT, the average change was 35.7U/L, while the average increase was 49.6U/L. The GGT measures are indicators of liver function, and are indicators of damage caused by harmful alcohol consumption. Following contact with SSSS, the average GGT score was 103.8U/L (98.6U/L for females, 113.3U/L for males). This is high.

However, of the 38 clients with two scores documented, 20 (53%) decreased their GGT levels; with 29% retaining or reducing their GGT levels to normal, another 8% of the cohort increased their GGT but remained in the normal range. Despite some clients having an increase in their GGT, more than half had a decrease; this is a positive result for the clients of the program. Elevated GGT levels, though an indicator of heavy long-term alcohol use; are also caused by other factors including antibiotics, seizure control medication, and anti-inflammatory drugs.

Alanine Amino Transferase (ALT)

Alanine Amino Transferase (ALT) is an enzyme found in the highest amounts in the liver. Tests for the level of these provides an indication of the damage to the liver. There were 111 clients in the file audit cohort had at least one ALT measure recorded in *Communicare*. As presented in Table 19 (page 61), 72% of the cohort had at least one ALT measure recorded. Normal scores were categorised as those of with ALT scores of less than 56IU/L, when possible two measures were compared for change in levels. Of those 101 with ALT measures recorded, 80% were within the normal range, with 20% of the cohort having raised ALT scores.

For female clients with one ALT measure, the pre-engagement measures ranged between 13 and 175IU/L, with a mean of 49.5IU/L. For male clients with one measure, the pre-engagement measures ranged between 23 and 245IU/L, with an average of 60.8IU/L; the post-engagement measures ranged between 38 and 474IU/L, with an average of 256IU/L.

Table 21: Alanine transaminase (ALT) (n= 101)

Level of risk	Pre measures N=91	% of total	Post measures N=47	% of total
Normal	73	80%	39	83%
Raised	18	20%	8	17%

	Females N=25	% of female	Males N=12	% of males	Total N=37	% of total
No change (Normal)	1	4%	1	8%	2	5%
Decrease						
To Normal	12	48%	3	25%	15	40%
Raised	2	8%	2	17%	4	11%
Increase						
Normal	8	32%	5	42%	13	35%
To Raised	2	8%	1	8%	3	8%

	Female	Male	Overall
Range pre-engagement	6 – 184	8 – 109	6 – 184
Mean pre-engagement	37.2	46.3	40.2
Range post-engagement	6 – 160	14 – 90	6 – 160
Mean post-engagement	33.9	41	36.5

Female clients with two measures recorded, had pre-engagement measures of ALT ranging between 20 and 245IU/L, with an average of 90IU/L; and post-engagement measures of ALT ranging between 12 and 455IU/L with an average of 98.6IU/L. For male clients with two measures recorded, pre-engagement measures of ALT ranged between 24 and 388IU/L, with an average of 107IU/L; and post-engagement measures of ALT ranging between 20 and 428IU/L, with an average of 98.4IU/L.

Overall, there was a decrease of 2.3 between pre and post-measures measures. Female clients had an average decrease of 2.6U/L, and the male clients had a decrease of 1.6IU/L in their ALT measures. Of the cohort with a decreased ALT, the average decrease was 17U/L; of those with an increase in ALT there was an increase of 15.3U/L. Of the 37 clients with measurable change, 19 decreased their ALT measures; with 40% maintaining or reducing their ALT measures to within normal range. Of the 16 clients with an increased ALT measure, 81% remained within normal levels. Overall following contact with SSSS, just seven clients (20%) had *raised* ALT scores.

Mean Corpuscular Volume (MCV)

The mean corpuscular volume (MCV) is a measure of the average size of one's red blood cells, the larger the cell the higher risk of complications for the client. Normal MCV levels are defined as being between 80–98.0 femtolitre. There were 107 clients in the file audit cohort that had at least one MCV measure recorded in *Communicare*. As presented in Table 19 (page 61), 76% (82% of females, 66% of males) of the cohort had at least one MCV measure recorded. Of those with MCV measures recorded 96 (90%) were either high or within the normal range, the remaining clients had MCV less than 80fL.

For female clients with one measure, the pre-engagement MCV measures ranged between 74.2 and 98.1fL, with an average of 85fL. For male clients with one measure, the pre-engagement measures ranged between 74.4 and 99.5fL, with an average of 85.8fL; the post-engagement measures ranged between 89 and 95fL with an average of 92fL.

Female clients with two measures recorded, had pre-engagement measures ranging between 65.6 and 97.2fL, with an average of 87fL; and post-engagement measures of MCV ranging between 71.7 and 105fL with a mean of 89.3fL. For male clients with two measures recorded, pre-engagement measures of MCV ranged between 77 and 97.4fL, with a mean of 87fL; and post-engagement measures ranged between 78–97.8fL, with a mean of 90fL.

Overall, there was an increase of between measures of MCV by 1.6fL; female clients had an increase in their MCV by 1.75fL, and male clients had an increase in their MCV by 1.1fL. Of those with an increased MCV, the average increase was 3.4fL; for those with a decrease, the average decrease was by 2.9fL. Of the 44 clients with two measures, 13 had a decrease in their MCV measure. The lower an individual's MCV the greater the concern, overall, 90% of clients maintained or changed their MCV to within normal levels. Just three (7%) of clients had MCV levels that were too low.

Table 22: Mean Corpuscular Volume (MCV) (n=107)

	Pre measures N=101	% of total	Post measures N=50	% of total
Low	11	11%	3	6%
Normal	88	88%	45	90%
High	2	2%	2	4%

	Females N= 31	% of female	Males N=13	% of males	Total N=44	% of total
Decrease						
Normal	9	29%	3	23%	12	27%
Normal to Low	1	3%	0	0%	1	2%
Increase						
Low	1	3%	1	8%	2	5%
Low to Normal	1	3%	0	0%	1	2%
Normal/ Normal to High	19	61%	9	69%	28	63%

	Female	Male	Overall
Range pre-engagement	65.6 – 98.1	74.4 – 99.5	65.6 – 99.5
Mean pre-engagement	86.3	87.8	86.8
Range post-engagement	71.7 – 105	78 – 97.8	71.7 – 105
Mean post-engagement	89.3	90.4	89.6

Summary of alcohol-related biochemical markers such as GGT, ALT and MCV

As with the diabetic related bio-medical markers, a small proportion of individuals had these measures recorded (see Table 19, page 61); just 33 (24%) of the 140 clients in the file audit had two measures recorded. Table 23 (page 66) summarises the number of clients by the type of change, and their level of risk. Although the cohort is small, there have been some clients who have made positive changes, and these are reflected in some of the positive results from the biomedical markers. In summary:

- 53% of clients decreased their GGT levels;
- 37% had GGT levels defined as within normal range;
- 56% of clients decreased, or remained the same, their ALT levels;
- 78% of clients had ALT levels within the normal range;
- 70% of clients increased their MCV rate; and
- 93% of clients had MCV rates within normal levels.

The greatest area for improvement is required in the GGT levels, with the least improvement and the smallest proportion of clients within the normal range.

Table 23: Summary of changes in alcohol-related bio-memical markers

	Females	Males	Total	*% of total*
Gamma-glutamyl Transferase (GGT) (n=38)				
Decrease	13	7	20	*53%*
Increase	13	5	18	*47%*
Normal	8	6	14	*37%*
High	18	6	24	*63%*
Alanine Amino Transferase (ALT) (n=37)				
No change	1	1	2	*5%*
Decrease	14	5	19	*51%*
Increase	10	6	16	*43%*
Normal	21	8	29	*78%*
Raised	4	4	8	*22%*
Mean Corpuscular Volume (MCV) (n=44)				
Decrease	10	3	13	*30%*
Increase	21	10	31	*70%*
Normal	29	12	41	*93%*
Low	2	1	3	*7%*

4.3 Enabling clients to manage their mental health issues and reduce their alcohol consumption

Performance indicators

Evidence of enabling clients to manage their mental health issues, and reduce their alcohol consumption is indicated and measured by:

- number of clients managed on a mental health care plan (MHCP)
- amount of income generated by the program, from *Medicare* , and other sources;
- file audit of clients, for changes in the management of depression by clients, through the monitoring of K5 scores; and,
- semi-structured interviews with sample of both engaged and non-engaged program clients.

4.3.1 Number of clients managed on a Mental Health Care Plan

Mental Health Care Plans (MHCP) are developed by the AOD therapists and AOD workers, with completion and final approval by the Medical Officer (GP). If deemed necessary, the GP will recommend and prescribe treatments including pharmacotherapy and structured therapy sessions, as part of the MHCP. Table 24 (page 67) presents the number of SSSS clients with completed MHCPS from between January 2010 to December 2011; 80 MHCPs were completed for SSSS clients. Since the start of the program, the number of clients with MHCPs steadily increased especially while the medical officer was based within the

program. Most notable about these data are of those with MHCPs 70% are female; the most likely contributing factor for this disparity is the lower proportion of male staff, especially given that a male clinical psychologist was not employed until May 2011. Having the medical officer based within the program, from February to June 2011, was a huge benefit; this is evidenced by the increase in the number of MHCPs from eight (July 2010) to 25 (April 2011); the departure of the medical officer resulted in a significant drop in the number of plans completed. The changes in the number of therapists and the limited access to GPs to complete the plans during the July to December 2011 period resulted in half the number of MHCPs. The completion of the MHCPs are necessary to claim *Medicare* income as reported in indicator Amount of income generated by the program, from Medicare, and other sources (Courts/ DOJ) (page 67).

Table 24: Total number of clients who have mental health care plans

	Female	Male	Total	Total clients	% of clients with
Jan – Mar 10	3	-	3	68	4%
Apr – Jun 10	-	-	0	145	0%
Jul – Sep 10	2	6	8	332	2%
Oct – Dec 10	0	1	1	307	0%
Jan – Mar 11	17	4	21	305	7%
Apr – Jun 11	21	4	25	278	9%
Jul – Sept 11	7	4	11	216	5%
Oct – Dec 11	6	5	11	243	4%
Jan 10 – Dec 12	56	24	80		

4.3.2 Amount of income generated by the program, from Medicare, and other sources (Courts/ DOJ)

As one of the original and key performance indicators, the generation of income by the program through *Medicare* is important. The original arrangement was for SSSS to claim *Medicare* income through the provision of structured therapy prescribed under MHCPs. Registered social workers and clinical psychologists are eligible to claim *Medicare* rebates for the provision of therapy prescribed by a GP under a MHCP. The amount of *Medicare* income generated by the program is dependent on the number of therapists that are qualified and registered for *Medicare*, and the completion of GP approved MHCP.

Table 25 (page 68) presents the *Medicare* income generated by SSSS from January 2011. There were 381 items claimed by the GPs and SSSS therapists for: focused psychological strategies (allied mental health); general practitioner attendances to which no other item applies; GP management plans, team care arrangements; GP mental health care; health assessments; and, psychological therapy services. Of the total $33,537.45 claimed

($29,943.45 paid), the SSSS therapists claimed $15,681.00 ($12,122.00 paid) for 138 items, and the GPs claimed $17,856.45 ($17,821.45 paid) for 243 items.

There has been $3,594 claimed but not paid. This difference is likely the result of the social workers claiming, but recent changes to eligibility has resulted in most of the social workers being ineligible to register. Changes to the Medical Benefits Scheme, require social workers to have extensive additional training in mental health to be able to register for *Medicare*. These changes were only introduced in late 2011, and will have an impact on the amount of income SSSS therapists will be able to claim in the future.

Table 25: Total *Medicare* income claimed by the SSSS program

Description	No. of items claimed	Amount claimed	Amount paid
Therapists			
Focussed psychological strategies	15	$1,007.60	$603.35
Psychological therapy services	123	$14,673.40	$11,518.65
General practitioners			
General practitioner attendances	17	$878.95	$878.95
GP management plans	28	$3,306.05	$3,306.05
GP mental health care	54	$7,816.65	$7,816.65
Health assessments	24	$4,804.80	$4,804.80
Management of bulk-billed services	120	$1,050.00	$1,015.00
Total	381	$33,537.45	$29,943.45

4.3.3 File audit of clients, for changes in the management of depression by clients, through the monitoring of: K5 scores

The K5 is a five-item version of the Kessler Psychological Distress Scale. The full version of the Kessler Psychological Distress Scale (K10) is a tool to identify 'high prevalence mental health disorders'[4]. The K6 is a modified 6-item scale to assess high distress. The K5 – an indicator used in the 2004–5 National Aboriginal and Torres Strait Islander Health Survey[4] – is the same as the K6, with the exclusion of one item for cultural reasons[5].

The introduction of the medical officer to the program, coupled with improved assessment procedures, resulted in an increase in the number of clients with K5 scores recorded. There are two sources of the K5 data, firstly the CAAC quarterly operational plan summaries, and the second is the file audit of identified SSSS clients. Between July 2010 and June 2011, there were 60 clients with 74 K5 scores recorded. As presented in Table 26 (page 69), a significant number of these scores were recorded between April and June 2011, with 32 female and 13 male clients having their score determined.

Table 27 (page 69) presents the number of clients with K5 scores recorded, and any change found between these scores and the April to June 2011 scores, and the scores recorded between July 2010 and June 2011. Between April and June, of the active clients, 23 (76.6%) had a K5 measure recorded; 16 of these only had one recorded. Two clients (8.7%) had no change in their scores, and five (21.7%) had an increase in their score. Between July 2010 and June 2011, there were 53 of the active clients with a K5 score recorded; however 43 (81.1%) only had one score recorded. Of the remaining ten: four had an increase in their scores; four had a decrease in their scores; and, two had no change.

Table 26: Number of clients and K5 scores recorded, 2011

	Female	Male	Total Number Of Clients	Number of K5 scores
Apr – Jun	32	13	45	-
Jul – Sept	31	14	45	53
Oct – Dec	36	7	43	60

Table 27: Changes in K5 scores, 2011

		Number with K5	Single K5 score	Increase	Decrease	No change
Apr – Jun	Number	23	16	5	0	2
	%	76.6	70	21.7	-	8.7
Jul – Sept	Number	29	27	1	1	-
	%	33.7	93.1	3.4	3.4	-
Oct – Dec	Number	14	14	-	-	-
	%	73.6	100	-	-	-
Jan – Dec 2011	Number	79	48	7	14	10
	%	86.8	60.7	8.9	17.7	12.7

File audit (K5)

Of the 140 file audited clients, 19 (13%) had at least one K5 scores recorded; ten (7% of females, and 8% of males) had two scores for comparison. All of these clients were diagnosed with depression; there was one additional client diagnosed with depression within the file audit cohort, but no K5 measures had been recorded. The K5 scores were categorised according to the level of distress[6]: low distress (1–5); moderate distress (6–11); highly distressed (12–17); and very highly distressed (18+).

As presented in Table 27 (page 69), of those with a K5 measure recorded, 73% had pre-contact and 72% had post-contact levels of either high or very highly distressed. The K5 scores ranged from seven to 23; all showed some level of distress. Overall, K5 scores increased by an average increase of two; females had an increase of 0.8, and males had an

average increase of 3.75. Those clients with a decreased K5, decreased their score by 4, while those that increased their score increased by an average of 6.4. Of the ten clients with two K5 scores, two remained moderately distressed with no change in their scores; three had a decrease in their K5 but remained moderately or highly distressed. The five clients increased their K5 score, three rose from moderate distress to high or very high distress.

These small numbers of K5 scores make it difficult to draw any conclusions regarding the change in client psychological wellbeing. These data do highlight the need for improved client assessment, with staff conducting all elements of the assessment process. Some of the staff noted that as clients reduce their alcohol consumption, and their psychological distress increases, as alcohol had been their coping strategy. It is not possible to examine this hypothesis due to the small number of K5 measures recorded. From the data in Table 27 (page 69), it appears that a greater decrease in K5 scores over a longer period with the program, thus it would be of great benefit to review these results after an extended period of contact with the program.

The program staff also raised concern about the appropriateness of the use of K5 as a measure of depression and mental health within the client group. Program staff were particularly concerned about the effect of translating the questions on the measures. Many staff, following the training with Indigenous Psychological Service's Dr Tracey Westerman (page 87) suggested using the measures developed by Dr Westerman. The Indigenous Risk Impact Screen (IRIS) is another suggested screening tool[7].

Table 28: File Audit K5 measures

Level of distress		Pre-contact	% of total		Post-contact	% of total
Moderate distress		4	27%		4	28%
Highly distressed		6	40%		5	36%
Very Highly distressed		5	33%		5	36%
	Females N= 6	% of female	Males N=4	% of males	Total N=10	% of total
No change						
Remained Moderately Distressed	1	17%	1	25%	2	20%
Decrease						
Remained Moderately Distressed	1	17%	0	0%	1	10%
Very High to Highly	1	17%	1	25%	2	20%
Increase						
Moderate to Highly/ Very high	1	17%	2	50%	3	30%
Remained Highly Distressed (Very)	2	34%	0	0%	2	20%

4.3.4 Semi-structured interviews with sample of both engaged and non-engaged program clients

Due to ethical considerations, the evaluators were required to access clients via their AOD workers and therapists. The staff were informed of the evaluator's visit, and were asked to invite clients to participate in interviews. However, only one opportunity was possible for the evaluator to meet with clients and this was during a women's bush trip in December. Much of this discussion revolved around the operation of the bush trips rather than experiences of clients with the SSSS. As an alternative, case studies prepared by the therapists have been used in this report to identify the outcomes for clients, and have been integrated throughout the report. One of the case studies provided, exhibited the value of the program for clients, providing assistance to *Luke,* a client who received valuable support and access to specialist mental health services:

> *Luke has recently re-engaged with his local mental health team who he refused to see in the past after some bad experiences with the team which he subjectively experienced as being related to cultural clashes which were difficult to resolve. With some active advocacy from our team, he has been recently seen by a psychiatrist who visits the social emotional branch and some small adjustments in his medication has been made. With some careful advocacy and support it appears that the trust is being rebuilt with mental health team.*

4.4 Decrease in the alcohol consumption and a change in drinking patterns of clients

Performance indicators

Evidence of a decrease in the level of alcohol consumed by clients and/ or a change in drinking patterns is to be indicated and measured by one performance indicator: AUDIT-C scores for both engaged and non-engaged clients (including relapse prevention maintenance) over time for all clients with 2 or more scores entered.

4.4.1 AUDIT C score for both engaged and non-engaged clients over time for all clients with 2 or more scores entered

The Alcohol Use Disorders Identification Test (AUDIT) is a validated tool developed by the World Health Organisation for this process. The Alcohol Use Disorders Identification Test Alcohol Consumption or AUDIT-C is a shortened but validated tool designed to specifically identity hazardous or risky consumption of alcohol, on a scale of 0–12[8]. As part of the SSSS assessment process, staff administered the AUDIT-C, and the score was recorded. A full AUDIT should be conducted to diagnose alcohol addiction or dependence, and is a validated measure to track and monitor changes in alcohol consumption. AUDIT-C is not as sensitive to change as the AUDIT, and not recommended as a monitoring or tracking tool. For example, a small change in drinking patterns, such as reducing drinking from five to four days per week will not necessarily be represented in these data. In the absence of another measure, the AUDIT-C scores have been used to monitor change in

client drinking patterns. Some case studies exhibit the diversity of changes by clients who have chosen to reduce their alcohol consumption, while others have chosen to abstain completely. The program is based on a harm minimisation model, with total abstinence just one of the options, clients are advised according to their individual situations. The following case studies provide an indication of the different changes in drinking patterns clients made following engaging with the program. Some of these changes are not reflected in the AUDIT-C scores discussed below.

Adam was keen on achieving a controlled drinking pattern and to attempt to limit his alcohol intake to somewhere between four and six standard drinks when he was drinking. He estimated that he was drinking between 15 and 20 standard drinks on any one binge drinking occasion which was usually two to three times a week.

Barry has subsequently markedly reduced his alcohol after approximately six sessions of motivational interviewing and relapse prevention and encouragement to obtain employment.

Last session Donna said she had not had a drink for two weeks and she was staying at home and doing things with her kids

Chrissy has stopped drinking completely, and now rings up every few weeks for a therapy session. These sessions are usually supportive psychotherapy, and just reinforce her progress.

June does not feel pressurised around drinking, has clearly stated that when she is working she does not drink as she prioritizes her work commitments and feels safe.

Olive stopped drinking, has resolved relationship issues, and all children have been returned to her. She's banned family from coming to her house to drink – having put a lock on the gate, but she allows them in for meals and getting together without alcohol.

There are two sources of the AUDIT-C data, firstly the CAAC quarterly operational plan summaries, and the file audit of identified SSSS clients. As shown in Table 29 (page 72), the CAAC quarterly operational plan shows that between July 2010 and June 2011 there were 122 clients with AUDIT-C scores recorded. For the April quarter, 74 clients had 113 AUDIT-C scores recorded. This increased from zero in September 2010.

Table 29: Number of current clients and AUDIT-C scores recorded

	Female	Male	Total No. of Clients	Number of AUDIT-C scores
Oct – Dec 2010	3	1	4	4
Jan – Mar 2011	35	29	64	108
Apr – Jun 2011	54	20	74	113
Jul – Sept 2011	34	21	55	71
Oct – Dec 2011	44	26	70	100

Table 30 (page 73) presents the number of clients with AUDIT-C scores recorded, and any change in the April quarter scores, as well as the scores recorded between July 2010 and

June 2011. For the April quarter, of the clients who were engaged (MHCP) in the program, 26 (86.6%) had an AUDIT-C score recorded; 15 of these only had one recorded. Four of the clients (15.4%) had no change in their score, and seven (26.9%) had an increase in their score. Between July 2010 and June 2011, there were 49 (77.7%) of the engaged clients that had an AUDIT-C score recorded; however of these 24 (38%) only had one score recorded. Of the remaining 25: ten had an increase; ten had a decrease; and, five had no change in their scores. Overall, the majority of SSSS clients with AUDIT-C scores recorded decreased their AUDIT-C scores between January and December 2011. The following data is a closer examination of each client's AUDIT-C score.

Table 30: Changes in AUDIT-C scores 2011

		Number with AUDIT-C	Single AUDIT-C score	Increase	Decrease	No change
Apr – Jun	Number	26	15	7	-	4
	%	86.6	57.7	63.6	-	36.4
Jul – Sept	Number	27	25	1	1	-
	%	31.3	93.7	50.0	50.0	-
Oct – Dec	Number	15	15	-	-	-
	%	78.9	100	-	-	-
Jan – Dec	Number	75	29	6	24	16
	%	82.4	38.6	13.0	52.2	34.8

All AUDIT-C scores

The AUDIT-C scores for clients identified in the file audit were reviewed. The first and the final scores were compared for change. Each score was categorised according to the SSSS definitions of the level of risk. There is a slight difference for cut-off levels for men and women, in the *at risk* category; those in the *at risk* category may be consuming at high risk levels if they have chronic medical conditions or are prescribed medication that may interact with alcohol.

AUDIT-C	**Level of risk (Females)**	**Level of risk (Males)**
0	No risk	No risk
1 – 3	Low risk	Low risk
4 – 5	At risk	At risk
6	High risk	At risk
7+	High risk	High risk

All the AUDIT-C scores recorded were also assessed, there were 544 AUDIT-C measures, for 311 individual clients. Of those 311 clients, 110 (35%) had more than one score recorded, the number of AUDIT-C scores ranged between two (51 clients) to 12 scores (one client). Of those with more than one score, 72% had two or three scores. Table 3 (page 15) provides a summary of the number of AUDIT-C scores recorded by client age group. Of those 201 with just one score: 22 had an AUDIT-C score of zero (no risk), 14 were at low

risk, 155 were drinking at high risk. Of those clients (110) with more than one AUDIT-C score, their first and final scores were compared. Thirteen experienced no change; three clients retained an AUDIT-C of zero, 58 had a decrease, and 40 increased their AUDIT-C scores, including five who increased their scores from zero.

Table 31 (page 75) presents the change in the AUDIT-C scores and the category of risk. Of the clients with an increase in their AUDIT-C scores: 2% increased their AUDIT-C scores, but remained at low risk; 3% increased from no risk to high risk. Of the clients starting in the low risk category (13), seven dropped to no risk or remained the same. Six clients increased their AUDIT-C scores, moving from low to high risk. Of the clients that started with AUDIT-C scores in the high-risk category (20), 14 increased their scores. Of the 69 that started in the high risk category, nine did not change their risk level and 15 increased their risk. Of those that decreased their AUDIT-C scores, 21 remained at high risk, and 14 dropped to low or no risk.

Of the 311 clients with AUDIT-C scores, 72 were identified as having MHCPs, and 38 of those had more than one AUDIT-C score recorded. Overall 55% decreased their AUDIT-C scores, 13% maintained their scores, and 32% increased their AUDIT-C score. Of those that decreased their AUDIT-C scores, 14 (67%) reduced their overall risk. Overall, a paired sample t-test found a small but significant decrease between the AUDIT-C at first measure and final measure t 2.15, df 105, pc0.05.

File audit (AUDIT-C)

The AUDIT-C scores for clients identified in the file audit were reviewed. The first and the final scores were compared for change. Each score was categorised according to the SSSS definitions of the level of risk. Of the 140 file audited clients, 121 (86%) had at least one AUDIT-C score recorded (91% of the female and 89% of male clients). Of this group, 36% had one AUDIT-C, 26% had two AUDIT-C scores, and 39% had three or more AUDIT-C scores. Of those file audited clients, 77% were consuming alcohol at high-risk levels. Nine per cent of the cohort started with an AUDIT-C score of zero (no risk). Of the 78 clients with two AUDIT-C scores 4% maintained no risk levels of consumption. Sixty per cent decreased their AUDIT-C scores; with 50% of these reducing their drinking to non-drinking or low risk levels. Thirty per cent increased their AUDIT-C scores, while the majority (75%) maintained high risk consumption levels, however 25% of this group started with no-drinking or low risk AUDIT-C scores – perhaps the result of entering the program from ASCC or a residential treatment program.

The level of alcohol consumption, and changes in drinking patterns, were monitored with the AUDIT-C scores of clients. Despite the full Alcohol Use Disorders Identification Test (AUDIT) being a more reliable screening and monitoring tool, a review of the staff notes provided as part of the staff survey (Table 5, page 32) showed that 43 (47%) clients had changed their drinking patterns. This is very close to the results for both cohorts in Table 31 and Table 32 shown from the AUDIT-C scores. Of all clients with two AUDIT-C scores

recorded 58 (52%) and of the active clients 43 (55%) reduced their AUDIT-C scores. Table 30 (page 73) shows that more AUDIT-C scores decreased over longer periods, rather than within a quarter; thus showing the benefits of longer engagement with SSSS. At least half of the clients that have engaged with SSSS have changed their pattern of alcohol consumption, consistent and rigorous monitoring by all program staff is needed, for increased reliability of this tool.

Table 31: AUDIT-C changes for all clients (n=110)

	Females N= 72	% of female	Males N=38	% of males	Total N=110	% of total
No Change						
No risk	2	3%	1	3%	3	3%
High risk	5	7%	4	11%	9	8%
Decrease						
To No risk	12	17%	2	5%	14	13%
To Low risk	4	6%	5	13%	9	8%
To At risk	3	%	5	13%	8	7%
High risk	14	19%	13	34%	27	25%
Increase						
To At risk	2	3%	1	3%	3	3%
To High risk	10	14%	2	0%	12	11%
High risk	20	28%	5	13%	25	23%

Table 32: AUDIT-C changes for *active* clients (n=78)

	Females N= 52	% of female	Males N=26	% of males	Total N=78	% of total
No Change						
No risk	2	4%	1	4%	3	4%
High risk	4	8%	4	15%	8	10%
Decrease						
To No risk	9	17%	2	7%	11	14%
To Low risk	3	6%	2	7%	5	6%
To At risk	3	6%	2	7%	5	6%
High risk	11	21%	11	42%	22	28%
Increase						
To At risk	2	4%	1	4%	3	4%
To High risk	5	10%	1	4%	6	7%
High risk	13	25%	2	7%	15	19%

4.5 Reduction in the levels of alcohol-related events experienced by SSSS clients following contact with the program

Performance indicators

The objective to reduce the level of alcohol-related events experienced by SSSS clients following contact with the program, is indicated by:

- change in the number of: alcohol-related and non-alcohol related presentation to CAAC clinic; alcohol-related presentations to both the emergency department and admissions to ASH; sobering-up shelter presentations; night patrol incidents; and alcohol-related protective custody offences; and,
- thematic analysis of semi-structured interviews with harm reduction service providers

4.5.1 Decrease in the number of alcohol-related: alcohol related and non-alcohol related presentation to congress; A&E alcohol-related presentations; alcohol-related admissions; SUS presentations; and, night patrol incidents.

This is an original performance indicator, however it is not able to be assessed for a number of reasons. Firstly, given the delays in acquiring the baseline data, some of these data were not available in a timely manner, and the data relevant to this reporting period was unlikely to be available for another 12 months. Secondly, the SSSS is a treatment program and it should not be expected that it would have an identifiable and measurable effect on the entire population. Thirdly, there are many confounding factors to consider as there have been many changes related to alcohol availability and other services provision since 2007 and it would not be possible to attribute any changes to SSSS alone.

As an alternative, it was decided that the number of presentations to the CAAC clinic, for acute and chronic episode for each client would be reviewed pre and post contact with SSSS, and provide a quasi-indicator of the extended effect. This data would provide an indication of client compliance and management of chronic disease. While collating the data for the file audit, it was found the data was inconsistent, and was not going to be reliable as an indicator as there were too many reasons for presenting to the clinic, and many clients were not presenting at the clinic. The collation of this data was discontinued.

4.5.2 Thematic analysis of semi-structured interviews with harm reduction service providers

In Alice Springs, in addition to the Alice Springs Hospital, there are just three key AOD harm reduction services – the Tangentyere Patrol, DASA sobering-up shelter, and the NT Police watch-house. The harm minimisation sector represented less than 3% of all referrals to SSSS, and averaged between two to three per quarter (Table 35, page 94). Most of these referrals were from DASA, however it is not evident if these clients were from the sobering up shelter, or if they were from DASA's other programs.

Until March 2011, two SSSS staff regularly went to the DASA sobering-up shelter when clients were due for release. According to both SSSS and DASA this arrangement worked well for the clients and the Shelter staff.

> *It's important to have the SSSS at DASA shelter in the mornings, doing the brief interventions in the morning. It's not their (shelter staff) foray. They need to be fed, cleaned up, return client belongings, for 20 clients. There is no time to do brief interventions.*

However it was unsustainable for the SSSS program, as there were only two staff willing and able to start early. Previously the same workers would also meet clients on their release from the police watch-house; however, the earlier release and the situation of clients (hung-over, hungry, and tired) meant that clients were very unwilling to engage.

4.6 Discussion

The focus of SSSS is to provide an ambulatory case management service through the provision of support and advocacy, structured therapy and medical treatment. The SSSS aims to support individuals and their families experiencing alcohol-related harms, improve their wellbeing, including their mental health issues, by assisting clients to reduce their alcohol consumption. The client case mix is complex: just 10% of active clients are in full-time employment, most are living with family, 51% have permanent accommodation, and just 40% prefer to speak English.

The SSSS has actively supported and assisted Aboriginal people in Alice Springs experiencing alcohol-related harms. The SSSS received 755 referrals; while assisting 614 (2010) and 620 (2011) clients and most of SSSS clients were female (53%) aged 40 years or over (40%). The program had contact with more clients than those referred to the program according to the data presented. This disparity is most likely the result of a combination of reasons: not all self-referrals and family referrals were recorded; some clients may have only had brief contact, such as attending a bush trip, but not engaged any further; and, changes to data recording processes have resulted in clients not being counted in the referral process. Whichever the cause, this difference highlights data recording issues, and the need for improved recording of activities.

Over the life of the program, the main source of referrals has moved from CAAC clinic to external sources. Evidence of this, is that in January 2010 quarter 66% of clients were referred from other CAAC departments, by the October 2011 quarter 62% of clients were from external agencies. This is a positive adjustment, showing the increased profile of the SSSS, and a further indicator of the need of such a service.

According to these data, there were just 103 clients with completed assessments, over the life of the program. The assessments were not formalised within the program until early in 2011, thus the lack of assessments prior to April 2011. Given the number of clients that – had contact with the program (1047), had more than one AUDIT-C recorded (311), and were active in December 2012 (140) – it would be expected that more AOD assessments

would have been completed. During the Program Review workshop in November 2011, it became apparent that there were different understandings of a completed assessment. Some staff noted a completed assessment when their part of the assessment was completed, rather than the entire assessment. In light of some of the low numbers of biomedical measures, and K5 scores available for the file audit, it would appear that many of the clients were engaged without a complete assessment. Given this inconsistency and the lower than expected number of completed assessments, two issues were identified: the need for accurate and consistent recording of activities by all program staff; and, the requirement for medical assessments as part of the assessment.

The ambulatory case management program has three streams: social and cultural support, therapeutic, and medical. The support and advocacy stream engaged, depending on the type of support, between two and 865 clients. The therapeutic stream engaged 153 clients in therapy. From the indicators related to the medical stream: 103 clients had completed assessments, 80 clients had completed MHCPs, and just 13 active clients received pharmacotherapy. It is expected that the support stream would have more clients and contacts; however, given the number of active clients (Table 5, page 32) one would expect a greater number of clients engaging in the medical and therapeutic streams each quarter. Even accounting for the barriers the program faced in 2010, it would be expected that there were a similar number of clients engaging in therapy as those with MHCPs. Even if this disparity is the result of inconsistent recording of activities by staff, the program appears to be heavily focused towards the support and advocacy stream and efforts need to be made to address this and develop the other streams of the program.

The bush trips have evolved into an important and valuable aspect of the program, with three different teams operating trips in 2012. The inclusion of the therapists in the trips is an even greater opportunity for therapeutic engagement with clients; however, it is not clear the degree to which this is a formalised aspect of the program. Now that there is a core group of regular attendees, there are possibilities for the bush trips. The benefits of the bush trips could be further enhanced through the development of a flexible program. Presently, the trips have some planning, but it appears that there is not a lot of continuity between each bush trip; a program would ensure that all key elements are addressed and that each group receives and benefits from the same information, and that the sessions do not become repetitive.

There are a number of outcomes for clients, due to engaging with the program. The identified goals of clients included: reduction of alcohol consumption; gaining employment or training; access to additional services; advocacy with other agencies: assistance in managing psychological or emotional conditions; gaining accommodation; and access to *Centrelink* entitlements. The evaluation has relied on program staff reporting of client outcomes; but the future of the program would benefit from formal monitoring of these key outcomes and treatment goals.

Based on staff reports and some of the data, some clients have achieved their goals with limited therapeutic intervention. As the data showed, much of the work of SSSS in 2010 was the provision of support and advocacy, some of these outcomes were the result of solely providing support and advocacy. This is perhaps the foremost reason contributing to the limited engagement with the therapeutic and medical streams. It is entirely possible that because of these positive outcomes with limited access to the medical and therapeutic streams there has been little persistence to engage with other streams of the program. However, the limited inclusion of the medical stream has resulted in limited outcomes and assessable results for the bio-medical indicators of the management of diabetes, and alcohol-related damage.

The results varied for all biomedical measures; however, the greatest indicator of these results is the inconsistency in getting these measures recorded. Not all measures were recorded for all clients, just 15 (54%) of the identified diabetic clients in the cohort having all of these measures recorded, thus making overall results difficult to assess. The limited data also prevents the ability to draw program-wide conclusions, this does not mean that the outcomes have not occurred, just that the wider conclusions cannot be drawn. Given that overall, more than half of those with two measures reduced, cholesterol levels, HbA1c levels, blood pressure, GGT levels ALT levels, and 90% of clients had positive MCV rates; there has been a significant effect resulting from the program.

The data indicating the achievement and ability of clients to manage their mental health issues and reduce their alcohol consumption, has been provided through a number of indicators. The data presented has not shown significant, if any, decrease in psychological distress of the clients, and in turn the management of mental health issues. It would be easy to conclude that the program has not assisted clients in the management of their mental health issues; however, this would be incorrect. Firstly, as showed in Table 27 (page 69), over a longer period (12 months) 45% of clients had a decrease in their K5 measures; this is a positive outcome for the clients of the program. As presented in Table 28 (page 70) the level of psychological distress of clients is high, a lowering of such levels is going to take time.

The level of alcohol consumption, and changes in drinking patterns, were monitored through the use of the AUDIT-C scores of clients. The AUDIT-C is a quick screening tool to identify if individuals are consuming alcohol at harmful levels. The full Alcohol Use Disorders Identification Test (AUDIT) is a more reliable screening and monitoring tool, which identifies if clients are consuming alcohol in a harmful or dependent pattern; this is a robust measure and designed for monitoring as well as screening of clients, and recommended as an appropriate monitoring tool for the SSSS. Despite this, about half of the SSSS clients, with AUDIT-C scores changed their drinking patterns, and this could be expected to improve through longer engagement with the program. Until October 2010, no AUDIT-C scores were recorded; however, from January 2011 between 21% and 29% of clients had an AUDIT-C score recorded. It is evident that some staff are diligent in their

monitoring of client progress; however, the proportion of clients with only one AUDIT-C score recorded, continues to highlight a gap in the program processes.

The ambulatory case-management stream of the *Safe and Sober Support Service* has shown some initial outcomes and impacts for clients. The indicators of performance have been achieved. The extent of the outcomes is greater than were originally expected; further analysis is require however to assess the extent of these changes. The physical, psychological, and social health and wellbeing of SSSS clients has been improved through SSSS, given some of the outcomes for clients. The needs of the client group are substantial, and these changes to clients' lives will assist clients in sustaining the changes in their lives. At least half of the clients that have engaged with SSSS have changed their pattern of alcohol consumption but consistent and rigorous monitoring by all program staff is needed for increased reliability of this tool.

The *Safe and Sober Support Service* has achieved the objective of improving the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program; however there is still room for improvement. The limited bio-medical measures reflect the limited access to the medical stream, and the program relies on, the most stable aspect of the program, the social support and advocacy aspect of the program. The program is now established, and has had some positive outcomes for clients. There are a number of areas that can be further developed to improve the service provision and exhibition the outcomes and achievements of clients.

It is recommended that consideration be given to:

1. ensuring that all streams of care are provided to clients, and identified monitoring measures are used.
2. improve the consistency of data recording and collecting, to ensure that the data accurately reflects the operation of the *Safe and Sober Support Service*.
3. ensuring that the program has full-time access to a medical officer, located within the SSSS offices, to ensure the provision of the medical stream.
4. developing a flexible program to be delivered on bush trips, to ensure that the bush trips have clear objectives and purposes, such as the provision of group therapy.
5. developing a clear and concise tool to monitor the client outcomes of the social support and advocacy stream of the program.

5 Results: Program Capacity Building

The establishment and development of the *Safe and Sober Support Service* is a core aim of the program and within this is the ongoing building of the capacity of the program staff. In addition to the employment and retention of qualified staff, the ongoing training of staff is important.

Objectives

The program capacity building has two objectives and is focused on the internal capacity building of the Program and staff, rather than external issues as discussed in AOD sector support & engagement (page 91). These objectives are:

- Employment and retention of well supported and trained program staff; and,
- Improve and build capacity of SSSS program staff [Internal].

5.1 Employment and retention of well supported and trained program staff

Performance indicators

During the first year of the program, there were a number of elements that were contributing to staff dissatisfaction and frustration, which lead to difficulty in retaining staff. These issues included the lack of clarity regarding the program policies and procedures, in particular the use and incorporation of the MHCPs. The following performance indicators were suggested to ensure that these process measures were included and implemented. The employment and retention of well supported and trained program staff will be indicated and measured through the following performance indicators:

- thematic analysis of program documentation [Staff and CRG meeting minutes];
- thematic analysis of semi-structured interviews with program staff;
- development of clear and appropriate program and operational procedures and documents: including referrals, case management, support, and advocacy tools;
- number and progress of individual CAAC career development plans; and,
- thematic analysis of semi-structured interviews with program staff regarding the use and development of the MHCP/ Stay Strong Care plans.

Program staffing

The original plan envisioned that by January 2011, nine casework teams of Aboriginal AOD workers and therapists (including the *GrogMob* team) would be in operation, with a ninth team to be employed in July 2011. According to the documentation provided, at full staffing, the program will have: manager; administration assistant; and nine casework teams

of therapist and Aboriginal AOD worker. These include two senior therapists and two senior Aboriginal AOD workers, and the *GrogMob* casework team.

Table 33: SSSS Staffing as at 31 December 2011

Position	Start – End Date	Cert IV	SMART RECOVERY training
Program manager	Jan-10 – Oct-10		
Program manager	Jan-11		
Administrative Assistant	Apr-10 – Jul-10		
Administrative Assistant	Jul-10		
Medical Officer (GP)	Feb-11 – Jun-11		
Snr AOD therapist (Clin. Psych)	Sep-10 – Jun-11		
Snr AOD therapist (Clin. Psych)	Jan-11		Sept 2011
Snr AOD therapist (Clin. Psych)	May-11		Sept 2011
AOD therapist (Counsellor)	Apr-10 – Dec-10		May 2010
AOD therapist (Counsellor)	Apr-10 – Jun-11		May 2010
AOD therapist (Clin. Psych)	Oct-10 – Jul-11		
AOD therapist (Counsellor)	Oct-10 – Aug-11		
AOD therapist (Social worker)	Feb-11	In progress	
AOD therapist (Psych)	Sep-11	In progress	
AOD therapist (Social worker)	Sep-11		
AOD therapist (Social worker)	Sep-11		Sept 2011
AOD therapist (Social worker)	Oct-11		
AOD worker	Apr-10 – Apr-11		May 2010
Senior AOD worker	Apr-10	In progress	May 2010
Senior AOD worker	Aug-10	CERT III completed	Sept 2011
AOD worker	Sep-10 – Jan-11		
AOD worker	Sep-10	In progress	Sept 2011
AOD worker	Apr-10	In progress	May 2010
AOD worker	Sep-10	In progress	Sept 2011
AOD worker	Sep-10	In progress	Sept 2011
AOD worker	Apr-10 – Aug-10 Aug-11	In progress	May 2010
AOD worker	Nov-11		
AOD Worker	*Jan-10 – Aug-11 Mat. Leave*	Completed	*May 2010*

Table 33 (page 82) presents the staffing of the SSSS. As of December 2011, the SSSS was staffed to 90% of the original plan, requiring just two AOD therapists and a medical officer. During the program, the staffing of the program has fluctuated, and this has affected the way in which the program has been able to operate. Overall, the AOD workers are the most stable cohort within the program, with just two resigning since the start of the program, a third had resigned from the program due to living location; however, was re-employed by SSSS on return to Alice Springs. Most of the resignations within the program have been therapists; three of these therapists resigned as they were planning to leave Alice Springs.

The greatest barrier to the provision of the SSSS has been in the recruitment and retention of the qualified and registered therapists and social workers. As the program requires therapists to be registered to claim *Medicare*. Three therapists employed during 2010 were not eligible to register for *Medicare*, by April 2011 all three of these therapists had resigned. The CAAC made concerted efforts to employ therapists that were *Medicare* registered, or eligible for registration, from January 2011. When the program model was conceptualised, social workers were eligible to register for *Medicare* and provide therapy under MHCPs; however, in late 2011 the eligibility criteria for social workers to register for *Medicare* changed. Social workers now need to have extensive experience working in mental health care. These changes have affected the number of SSSS social workers eligible to register with *Medicare*, and will have future impact on the Program and *Medicare* eligibility.

5.1.1 Development of clear and appropriate program and operational procedures and documents: including referrals, case management, support, and advocacy tools.

Early in the establishment and operation of the program, it was identified that one of the barriers of SSSS was the lack of an established program and operational procedures. The lack of these procedures, including an orientation package and guidelines for new staff, resulted in much confusion and frustration for the staff. The development and implementation of such procedures took time; by December 2011, all were developed and available electronically on SSSS server space. Some of the changes implemented included improvements to the referral system. The referral process now requires additional information from the referring agency to ensure that the client is aware of the referral, and so that SSSS have an indication of the appropriateness of the referral. An orientation package for new staff and an operational procedures manual have been prepared, and are in use.

The SSSS held an internal workshop in early November 2011; from this workshop, it became evident that many staff had different understandings of certain processes and procedures, such as AUDIT-C, K-5, and the AOD assessments. It became apparent during the meeting that many staff members were recording the information differently in *Communicare*. The processes and procedures were clarified during the meeting; however to ensure consistency across the Program it is highly recommended that regular reviews with staff of these processes are conducted.

5.1.2 Number and progress of individual CAAC career development plans

Progress on the development of individual career development plans for each staff member was slow. Only two of the SSSS staff mentioned these plans, one discussed the difficulties in negotiating the agreement. The SSSS manager ensures that these plans are conducted with SSSS staff annually.

5.1.3 Thematic analysis of semi-structured interviews with program staff regarding the use and development of the MHCP/ Stay Strong Care plan

This performance measure was implemented when very few MHCPs had been completed, and staff had a number of barriers preventing the completion. As mentioned previously, the mental health care plans (MHCPs) are an important element of the Program (page 66). The MHCP requires social, medical, and psychological assessment of the client. Following the assessments, the MHCP outlines the treatment plan for the client. Initially there was confusion regarding the use and applicability of the MHCPs within the program. The lack of clarity and limited training in the use of the *Stay Strong Care Plans* resulted in very few plans being completed. Another factor contributing to this was the difficulty staff had in getting the MHCPs approved by GPs in the CAAC clinic. In 2011, the program procedures were clarified and improved. As part of the improvements, formal AOD and medical assessments were introduced, and the *Stay Strong Care Plans* were abandoned, and replaced with MHCPs. At a similar time, a medical officer was placed in the SSSS. The effects of these changes, coupled with more therapists, increased the completion of many more MHCPs.

The staff identified the greatest barrier to the completion of MHCPs as receiving timely access to the GPs in the CAAC clinic. Some of these concerns included: difficulties getting appointments; and following this continuity of care for follow up appointments. To address this in February 2011, Dr Denise Thomas became the SSSS medical officer/GP, working half time between SSSS and ADSCA. The addition of the SSSS medical officer, and a consulting room in the SSSS offices, was a huge benefit to the program. As previously discussed (page 67), the number of SSSS clients with MHCPs increased following the inclusion of the medical officer on the program. All staff have stated that the MHCPs are happening because of the presence and assistance of the medical officer.

The benefits of the medical officer for staff were greater than the completion of MHCPs. According to staff, the medical officer has facilitated the regular use and recording of the AUDIT-C, K5 and chronic disease management by the staff. In addition to this, locating the medical officer in the program also improved the case management for clients. All staff discussed the value of having the medical officer on-site, as they are able to get new clients to see the medical officer early in their contact with the program. However, it is more difficult for the longer-term clients, as they have already engaged with the program and generally are unwilling for more than advocacy and support.

Since the resignation of the GP, SSSS have worked closely with the CAAC clinic for the completion of MHCP; as can be seen in Table 24. Despite this, there was a decline in the

number of MHCPs completed since July 2011. By the end of 2011, staff were comfortable with the completion of the MHCPs, however many continually expressed regular frustration with access to the CAAC clinic. The decrease in the number of MHCPs is the result of the limited access to the CAAC clinic, rather than the staffs' unwillingness to complete the Plans.

5.2 Improve and build capacity of SSSS program staff [Internal]

Performance indicators

To ensure that staff are supported, and have regular opportunities for capacity building, the following performance indicators are:

- provision of appropriate training;
- number and type of AOD training courses offered, and level of participation;
- number of AOD workers actively completing Certificates II to IV in Community services – Alcohol & Other Drugs;
- number of SSSS program staff trained in AOD in self-management and recovery programs;
- number of SSSS program staff receiving cultural competency up-skilling; and,
- thematic analysis of program documentation [training related].

5.2.1 Provision of appropriate training

The SSSS have accessed a variety of training and professional development, as outlined in Table 34 (page 87). Though not all of the training provided has been specifically AOD-related, the training was appropriate to the role of the staff, such as first-aid training. Most of the staff were happy with the type and level of professional development opportunities, especially those who attended the art therapy course in April 2011 and all have discussed how they would integrate this into the program. One suggestion was the integration of art therapy into the women's bush trips.

Early in the program, one issue highlighted by the therapists, particularly the clinical psychologists, is the need for regular accredited professional development to maintain their accreditation. Given the difficulties in employing the psychologists, the retention of the therapists is important. Efforts were made in 2011 for the clinical psychologists to have access to such training, however this requires formalisation to ensure that therapeutic staff are retained, especially those eligible to claim *Medicare*.

5.2.2 Number and type of AOD training courses offered, and level of participation

Continuing from the previous performance indicator, Table 34 (page 87) presents the type of training that SSSS program staff participated in since May 2010, due to staff changes details of training prior to September 2010 are limited. The majority of the training, though

not specifically related to AOD issues, was relevant to the roles of staff. Training ranged from participation in forums, attending AOD conferences, and mental health training.

Participation by SSSS staff in these training courses varied, with only three courses available for all staff – SMART RECOVERY, AIMHI and First Aid training. In 2011, three groups of SSSS staff attended interstate AOD conferences – Australian Winter School, Drug and Alcohol Nurses Association, and Australasian Professional Society on Alcohol & Other Drugs (ASPAD). One of the AOD workers presented with the evaluator at the ASPAD conference. The interstate conferences are important for the SSSS staff for a number of reasons, including providing staff with the opportunity to hear what is happening with the AOD field, and meet others working in the AOD-field. As mentioned previously the clinical psychologists are able to maintain their accreditation through the attendance at selected conferences each year.

5.2.3 Number of AOD workers actively completing Certificates III to IV in Community services – Alcohol & Other Drugs

As a condition of employment for all AOD positions in the Northern Territory funded by the AODP, the SSSS staff are required to complete Certificate IV in Community Services (Alcohol And Other Drugs). Of the current staff, one AOD worker was enrolled in the Certificate III, seven AOD workers and two therapists were enrolled in Certificate IV in Community Services, these are outlined in Table 33 (page 82).

The worker enrolled in the Certificate III course completed it through the Council for Aboriginal Alcohol Programs Service in Darwin (CAAPS), a registered training organisation (RTO). The 12-month course, Certificate III Community Services Work (Strong Spirits, Strong Minds) is offered in a block-release format enabling workers the opportunity to focus entirely on their studies for a week or two at a time. One of the AOD workers completed the Certificate IV in early 2011, and had since enrolled in a Diploma of Counselling.

The SSSS AOD workers completing the Certificate IV were enrolled through the Alcohol and Drug Service of Central Australia (ADSCA). The course is a self-paced external study program. Many of the AOD workers have expressed the greatest difficulty being to setting aside uninterrupted blocks of time to complete their studies. Most of the AOD workers have expressed frustration at prioritising the completion of the course over other commitments, especially over demands of clients. To address this SSSS staff have been assigned Friday as a no client day and from June 2011 trainers from ADSCA visit the SSSS office weekly to assist the staff with their studies. The outcome of these changes is not yet evident. Other agencies also highlighted the frustration with the inconsistency of the Certificate IV course facilitators.

Table 34: Number type of AOD training courses accessed, and level of participation

Name of training	Date	Training organiser	No. of SSSS staff
SMART RECOVERY	*May 10*	*SSSS coordinated*	*7*
AIMHI	*Oct 10*	*SSSS coordinated*	*13*
SMART RECOVERY	*Sept 11*	*SSSS coordinated*	*7*
Brief Intervention	Sept 10	ADSCA	6
Accidental Counsellor	Oct 10	Lifeline Australia	5
Assessment Training	Nov 10	Turning Point	2
Narrative Therapy	Dec 10	Dulwich Centre	3
Mental Health Assessment of Aboriginal Clients: Indigenous Psychological Services	Feb 11	MHACA	4
First aid training	Mar 11	Eagle Training Services	11
Introduction to Art Therapy workshop	Apr 11		6
Shared care after separation workshop	Apr 11	Alice Springs Family Law Pathways Network	2
Working with Families & Significant Others	May 11	Headspace Alice Springs	1
Early Identification of Psychosis in Young People	May 11	Headspace Alice Springs	1
NT Health GP Workforce PD	May 11	GP Network	1
Diabetes Care at the Centre	Jun 11	Baker IDI	1
Australian Winter School [interstate]	Jun 11	Alcohol and Drug Foundation Queensland	3
AOD Motivational Interviewing	Jun 11	Turning Point, Victoria	3
Drug and Alcohol Nurses Association Conference	Jun 11	Drug and Alcohol Nurses Association	3
The Journey Towards Cultural Competence with Aboriginal and Torres Strait Islander Peoples for Nonindigenous Mental Health Practitioners	Jul 11		2
Alice Springs Healing Forum	Oct 11	Aboriginal and Torres Strait Islander Healing Foundation	5
Indigenous Families in the Family Law System forum	Oct 11	Relationships Australia	1
Engaging and Motivating Difficult Clients	Nov 11	Positive people solutions	4
Australasian Professional Society on Alcohol & Other Drugs Conference	Nov 11	APSAD	5
Apply First Aid	Nov 11	Eagle Training Services	4
Sexual Assault Awareness	Nov 11	Sexual Assault Referral Centre	2
Apply First Aid refresher	Dec 11	Eagle Training Services	2
Northern Territory Early Intervention Pilot Program	Dec 11	Northern Territory Police Force	1

5.2.4 Number of SSSS program staff trained in AOD in self-management and recovery programs

As part of the original plan for SSSS, it was decided that the Program would have all staff trained in *Smart Management and Recovery Training* (SMART RECOVERY).[9] SMART RECOVERY is a self-help group that also uses the principles of Cognitive Behavioural Therapy to assist people to manage their thoughts and actions, through problem solving skills.[8&9] Training for facilitators in Alice Springs is irregular. There have been two opportunities for facilitators to be trained, both of which have been facilitated by SSSS. Ssss participation in the course is presented in Table 33 (page 82). In May 2010, seven of the SSSS staff were trained in SMART RECOVERY; following the training SSSS staff felt that the program was not appropriate for the client group. Ssss facilitated further training in SMART RECOVERY, in September 2011; another SSSS seven staff completed this training. A further five current staff members are still to be trained in SMART RECOVERY. During the second training opportunity, SSSS therapists attempted to discuss, with the trainers, ways the program could be modified for the SSSS client group. The trainers were adamant that the program could not be changed or adapted. Following this advice, the SSSS have decided SMART RECOVERY is not a culturally appropriate tool for this program, and will not be implemented as part of the SSSS.

5.2.5 Number of SSSS program staff receiving cultural competency up-skilling

The cultural competencies are important to ensure a culturally safe and secure program, as most of the therapists are not from Alice Springs and only one is Aboriginal, but not from this region. The cultural competency and up-skilling within the SSSS Program was to be provided by the senior AOD Aboriginal workers. There is no formal training or assessment of cultural competency of staff. Since December 2010, Debra Maidment conducted a small number of training sessions on cultural competency for all CAAC SEWB staff, and regularly provides informal sessions for SSSS staff. In addition to this, cultural guidance is provided daily through the partnership of therapist and AOD worker. The senior clinical psychologists also participated in a two-day cultural competency workshop, endorsed by the Australian Psychological Society: *The Journey Towards Cultural Competence with Aboriginal and Torres Strait Islander Peoples for non-Indigenous Mental Health Practitioners.* The cultural up-skilling of staff is important, particularly those that are not from Alice Springs and are not Indigenous Australians.

Cultural competencies are vital to the program, ensuring that all staff provide the program in a culturally secure and safe manner. The original model of partnership of both AOD worker and AOD therapist working together, is one way that cultural security and safety is provided. It is suggested that in addition to the informal daily guidance provided by the AOD workers, that formal cultural competencies and training be provided to all SSSS staff external to the program. The provision of externally providing training would ensure that *all* staff participate and are provided with the same information. In addition to externally facilitated training, consideration should be given to implementing an external cultural

'supervisor' for the Program manager, just as the clinical psychologists have an external clinical supervisor.

5.2.6 Thematic analysis of program documentation [training related]

This indicator is included to comment on the quality of the training and professional development provided to the SSSS staff; however, no documentation was available about the training provided to SSSS staff.

5.3 Discussion

The building and development of the internal capacity of SSSS has been improved across each quarter. Consistent efforts were made to continue to build capacity of the *Safe and Sober Support Service*. In the provision of the program, efforts were made to employ and retain a qualified staff through the development of career development plans, access to a variety of training, and including specific AOD qualifications. However, the July 2011 quarter was difficult, due to a shortage of therapists. The recruitment of four therapists the following quarter has resulted in a Program almost at its targeted capacity. The turnover of the therapists has greatly affected the program, and consideration should be given to why there has been such change in this aspect of the program.

The plethora of training that SSSS staff participated in was relevant to the Program. In addition to these training sessions, many SSSS staff are enrolled in Certificates III and IV in Community Services; however a number of staff have been working on these qualifications for more than a year, the progress made has not been discussed. These qualifications are the minimum requirement for the sector, and efforts should be made to ensure completion within a reasonable timeframe.

A number of staff have participated in other training and professional development opportunities, spending between two and six per cent of 2011 in professional development. Previously it was recommended that an audit of staff skills be conducted, and there be planning of professional development opportunities to address the skill gaps of each individual; this would make professional development opportunities strategically beneficial to the SSSS. This does not appear to have been implemented; however, a similar process is conducted for the career development plan.

Staff retention is important for the success of the Program and for the wellbeing of clients. The loss of four therapists between May and August 2011 placed the SSSS and remaining staff under strain; however as recruitment was already in progress the employment of the additional therapists was relatively quicker than previous recruitment rounds. The resignations in 2011 were unavoidable; this does pose a risk to the provision of the Service. Given the difficulty recruiting and retaining therapists for the program, consideration should be given to a regular recruitment process for these positions; as yet all positions have not ever been filled.

The training of staff in SMART RECOVERY has occurred; however, there does not appear to be a clear plan of integrating this into the SSSS program. It is recommended that there is an integration plan, before the remaining staff are trained. If SMART RECOVERY is not appropriate for the SSSS client group, then an alternative program and training should be sought.

Cultural competencies are vital to the program, ensuring that all staff provide the program in a culturally secure and safe manner. The original model of partnership of both AOD worker and AOD therapist working together, is one way that cultural security and safety is provided. The lack of a formal cultural competency training program, is a limitation of the program. It is suggested that in addition to the informal daily guidance provided by the AOD workers, that formal cultural competencies and training be provided to all SSSS staff external to the program. The provision of such training would ensure that *all* staff are working from the same foundation, and share the same competencies. External direction would ensure that the training does occur, rather than it being seen as a low priority; presently staff workload has prevented the formalisation of training within the Program.

In addition to this training, consideration should be given to implementing an external cultural 'supervisor' for the Program manager, just as the clinical psychologists have an external clinical supervisor. Presently, senior AOD workers provide this guidance; however, this requires staff members to direct the program manager creating a difficult dynamic within the program. An external supervisor/ adviser – similar to a clinical supervisor – would provide external guidance for the program manager.

Overall, there has been significant effort placed on building the internal capacity of the SSSS. There are a number of changes recommended to further develop and build the capacity of the program.

It is recommended that consideration be given to:

6. conducting regular reviews of program processes – especially regarding the inputting of data into *Communicare* – to ensure consistency across the Program.
7. review and further exploration of the factors influencing the retention of the program therapists, and the recruitment of additional therapists.
8. ensuring that all staff enrolled, complete the Certificate IV, within a specified timeframe.
9. formalising the *Cultural competency* training, including the exploring the external facilitation of the training.
10. introducing an external cultural advisor/ supervisor/ mentor for the position of the program manager.

6 Results: AOD Sector Support & Engagement

Introduction

The third aspect of the SSSS is the wider engagement and partnership of the AOD-sector and social services in Alice Springs, with the purpose of increasing inter-agency collaboration, decreasing the duplication of services, and filling the gaps in service needs. Key agencies in Alice Springs have membership on the CRG. Initially the CRG were heavily involved in the wider development and establishment of the SSSS. Through the CRG participation, referrals to and from the SSSS were managed and collaboration improved. In addition to this, the AOD sector in Alice Springs was up-skilled through provision of ongoing training for SSSS staff in AOD and cultural competencies.

Objectives

There are two objectives for the sector support and engagement:

- establishment of a well-supported interagency AOD network in Alice Springs; and,
- improve and build capacity within wider AOD sector [external].

6.1 Establishment of a well-supported interagency AOD network in Alice Springs

Performance indicators

As SSSS is a treatment-focused program, a well-supported interagency AOD and social support network is vital to the wider operation of the SSSS. The AOD services and social support agencies in Alice Springs are represented on the SSSS Co-ordinated Reference Group (CRG). One of the purposes of the CRG is for open discussion regarding the operation of SSSS and collaboration with other agencies. The following performance indicators will provide an indication of the establishment and operation of an AOD network in Alice Springs:

- number of clients referred to the program, by source;
- number of case-managed clients across AOD services;
- participation by AOD sector members in CRG meetings;
- thematic analysis of program documentation [meeting minutes];
- establishment of formal collaboration [service] agreements between agencies;
- semi-structured interviews with key stakeholders and program partners and thematic analysis of semi-structured interviews with key stakeholders and program partners; and,

- thematic analysis of semi-structured interviews with community members.

6.1.1 Number of clients referred to the program, by source

The number of clients referred to the SSSS program, by source, are presented in Table 35 (page 94). Between January 2010 until December 2011, *755 clients* were referred to the SSSS, by more than 42 different sources. Overall, the number of referrals, averaged 99 per quarter, has ranged from 41 in the first quarter to 147 in July 2010 quarter. Twelve agencies averaged more than one referral per quarter (total of eight or more). There were only two consistent sources of referrals since January 2010, CAAC and self-referrals; Alice Springs Hospital and Community Corrections only had one quarter with no referrals to SSSS. In early 2011, referral procedures were clarified and improved; since then four agencies referred every quarter: Alice Springs Hospital, Central Australian Mental Health Service; Alcohol and Drugs Service of Central Australia, and Community Corrections.

Figure 5: Number of referrals by month by source January 2010 to December 2011.

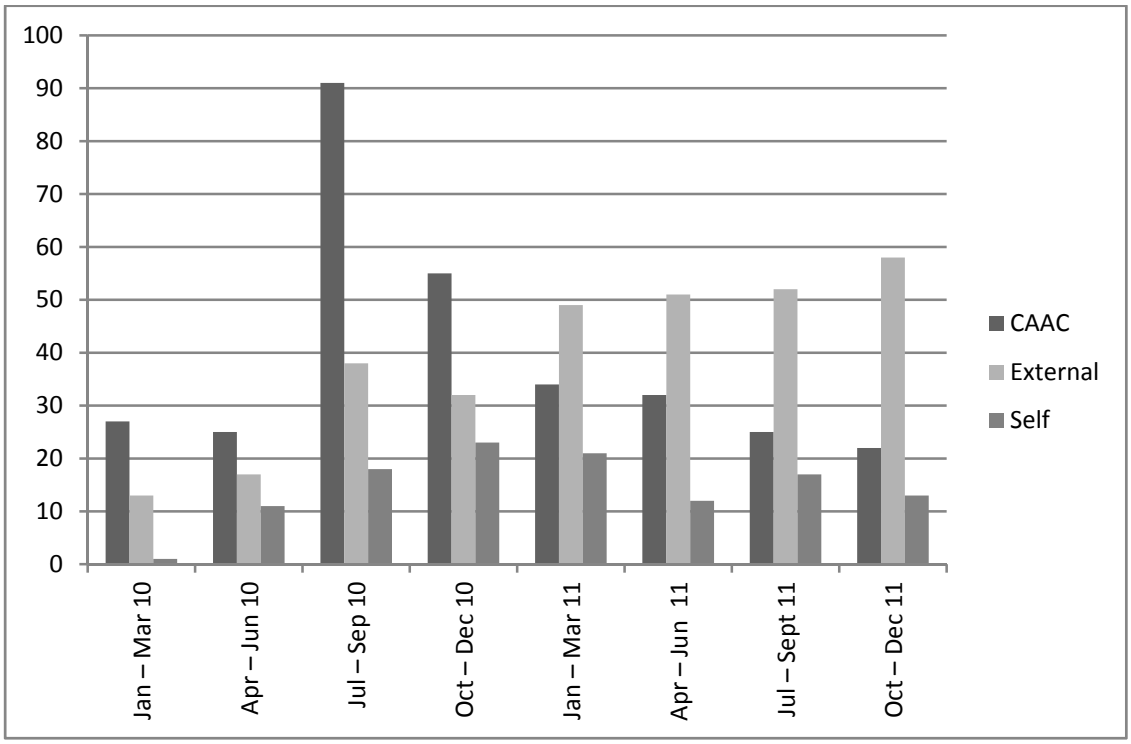


Figure 5 (page 92) summarises the number of referrals to SSSS, by source, with a differentiation between the external referrals from CRG members and other agencies in Alice Springs. The sources of these referrals are grouped into different system types: health and families, Alice Springs AOD sector, justice, harm minimisation, youth sector, community organisations and government departments.

Health and families sector

The majority of referrals (51%) have come from the Health and Families sector. CAAC provided 80% of the referrals for the Health and Families sector – with referrals from the

Clinic, Ingkintja, Social and Emotional Wellbeing, Community Wellbeing, and Targeted Family Support Services. Eleven other agencies referred clients to SSSS, with the total number of referrals from each agency over the two years, ranging between one and 23.

Alice Springs AOD sector

The alcohol and other drugs sector provided 17% of the total number of referrals. Four AOD agencies have referred clients to SSSS, with the majority 81% coming from ADSCA.

Justice sector

Just 4% of referrals came from the seven justice agencies, which referred 32 clients to SSSS, averaging four referrals per quarter.

Harm minimisation and youth sectors

The referrals from the harm minimisation and youth sectors, each accounting for just 2% of all referrals, were limited. The majority of the harm minimisation referrals (89%) came from DASA. Five youth agencies made 14 referrals to SSSS, however these may not be for youth, rather the referrals may have been for the parents of the young people. In addition, it must be noted that Bushmob, the only youth agency on the CRG, made no referrals.

Other sources of referral

In addition to four government departments making referrals to SSSS, at least ten community agencies made referrals to SSSS. Second only to CAAC, self-referrals were the most frequent source of referral. Self-referrals are clients who heard about the program through a flyer, or the experiences of friends and family engaging in SSSS. Since January 2010, an average of 14 clients per quarter referred themselves to the program. CRG members accounted for 26% of all referrals and 60% of all external referrals.

The data on the number of referrals does not indicate the number of clients that have engaged with the SSSS, nor the degree of engagement. These data provide a small indication of the work with outside agencies. The diversity of referral services, during the past year, indicates that many organisations and agencies are aware of the SSSS; however, the small number of referrals from these agencies means that not all possible clients are referred. The number of referrals from other agencies is small; effort needs to be made by other agencies to establish links with the SSSS, especially to refer clients with alcohol issues. It must be noted that referrals from some agencies come from just one or two individuals, thus when these staff members are on leave the referrals decline. It is also possible that some clients are referred more than once by different agencies. There was some discussion by the CRG members that the number of referrals from their agencies does not match the number of referrals into SSSS. The terms of reference for the CRG outline that data would be shared by all parties, it was recommended that all these data are shared by all agencies.

Table 35: Number of clients referred by system type

		Jan – Mar 10	Apr – Jun 10	Jul – Sep 10	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11	Oct – Dec 11	*Total*
HEALTH & FAMILIES										
	Alice Springs Hospital	1	3	8	0	5	1	1	4	*23*
*	Alice Springs Hospital (AOD)	0	0	0	3	2	0	1	0	*6*
	Amoonguna Health Services	0	0	2	0	0	0	0	1	*3*
	CAAC	27	25	91	55	34	29	21	16	*298*
	CAAC: Community Wellbeing Team	0	0	0	0	0	0	1	0	*1*
	CAAC: Ingkintja	0	0	0	0	0	1	0	0	*1*
	CAAC: Social and Emotional Wellbeing	0	0	0	0	0	2	3	2	*7*
	CAAC: Targeted Family Support Service	0	0	0	0	0	0	0	4	*4*
	CAMHS (MHU)	0	0	1	1	1	4	1	3	*11*
	Child Health	0	0	0	0	0	1	1	0	*2*
	Flynn Drive Renal Unit	0	0	1	1	0	0	2	0	*4*
*	Headspace	0	0	2	0	0	0	0	0	*2*
	Mental Health Association of Central Aust.	0	0	1	0	0	0	0	0	*1*
	Nganampa Health	0	0	1	0	0	3	0	0	*4*
*	Northern Territory Children & Families	0	0	1	9	2	0	1	3	*16*
	Western Desert Nganampa Unit	0	0	1	0	0	0	0	0	*1*
	Western Aranda Health Aboriginal Corp	0	0	2	0	0	0	0	0	*2*
	Subtotal	*28*	*28*	*111*	*69*	*44*	*41*	*32*	*33*	*386*
ALICE SPRINGS AOD SECTOR										
	ADSCA	4	0	0	8	16	21	30	27	*106*
**	Alice Springs Hospital (AOD)	0	0	0	3	2	0	1	0	*6*
	CAAAPU	0	0	1	0	2	0	0	0	*3*
*	DASA	4	3	0	1	3	0	4	1	*16*
	Sub-total	*9*	*6*	*1*	*12*	*23*	*21*	*35*	*28*	*131*
JUSTICE REFERRAL SYSTEM										
	Alice Springs Correctional Centre	0	0	0	0	1	0	0	1	*2*
	Community Corrections	0	1	2	1	1	5	3	2	*15*
	Alice Springs Court / SMART Court	0	0	0	1	0	1	1	1	*4*
	Central Australian Aboriginal Legal Aid Serv.	0	0	0	0	2	2	0	3	*7*
	Central Austn. Aboriginal Family Legal Unit	0	0	0	0	0	1	0	0	*1*
	Central Australian Women's Legal Service	0	0	0	1	0	0	0	0	*1*
*	NT Department of Justice	0	0	0	0	0	1	1	0	*2*
	Sub-total	*0*	*1*	*2*	*3*	*4*	*10*	*5*	*7*	*32*

		Jan – Mar 10	Apr – Jun 10	Jul – Sep 10	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11	Oct – Dec 11	*Total*
HARM MINIMISATION REFERRAL SYSTEM										
	Central Australian Women's Shelter	0	0	2	0	0	0	0	0	*2*
**	DASA	4	3	0	1	3	0	4	1	*16*
	Sub-total	*4*	*3*	*2*	*1*	*3*	*0*	*4*	*1*	*18*
YOUTH SECTOR										
	Alice Springs Youth Accommodation Support Service	0	0	0	0	0	1	0	0	*1*
	Child Abuse Taskforce Southern	0	0	0	0	0	0	0	1	*1*
**	Headspace	0	0	2	0	0	0	0	0	*2*
	CAYLUS	0	1	0	0	0	2	0	0	*3*
	Family Support Unit	0	0	0	0	0	2	4	1	*7*
	Subtotal	*0*	*1*	*2*	*0*	*0*	*5*	*4*	*2*	*14*
COMMUNITY ORGANISATIONS										
	Anglicare	0	0	0	0	0	0	0	1	*1*
	Catholic Care	0	0	0	1	1	0	0	2	*4*
	Central Land Council	0	0	0	2	0	0	0	0	*2*
	Irrekerlantye	0	0	6	0	4	0	0	0	*10*
	Mission Australia	0	0	0	0	0	0	0	6	*6*
	Salvation Army	0	0	1	0	0	1	0	0	*2*
	Santa Teresa	0	0	0	0	0	0	1	1	*2*
	Tangentyere Council	1	1	2	2	0	2	1	0	*9*
	Yarrenyty Alterre Learning Centre	0	0	0	0	0	1	0	0	*1*
	Other	0	18	0	0	5	0	0	0	*23*
	Self	1	11	18	23	21	12	17	13	*116*
	Subtotal	*2*	*30*	*27*	*28*	*31*	*16*	*19*	*23*	*176*
GOVERNMENT DEPARTMENTS										
	Centrelink	0	0	0	0	0	2	0	0	*2*
**	Northern Territory Children & Families	0	0	1	9	2	0	1	0	*16*
**	NT Department of Justice	0	0	0	0	0	1	1	0	*2*
	Territory Housing	3	8	4	1	4	0	0	0	*20*
	Sub-total	*3*	*8*	*5*	*10*	*6*	*3*	*2*	*3*	*40*
	GRAND TOTAL	*41*	*71*	*147*	*110*	*104*	*95*	*94*	*93*	*755*

*Some agencies are included in more than one sector grouping as they fit into both; however, they are not duplicated in the grand total.

6.1.2 Number of case managed clients across AOD services

This performance indicator is similar to *Number of clients being case managed* (page 53); however, this indicator is focused specifically to address case management of clients with *external services* in Alice Springs. The processes for recording case management of clients with other services and agencies were developed and implemented during the April 2011 quarter.

Originally it was agreed that the best indication of the number of clients being case managed across services, were the number of clients on MHCP as presented in Table 24 (page 67) however this is not an accurate measure as it is based on assumptions that only clients with MHCPs are being case managed, which is not the case. Case management is coded if SSSS is the lead agency in the care of the client. In addition to this, other coding is also used. AOD workers or therapists code case conferences when a conversation is had with an external agency with the client present. Case discussions are coded when a discussion/meeting is had with other agencies or other CAAC program staff are involved with the client, client is not present however has given consent. Data specifically about the referrals from SSSS, and the specific agencies with case management occurs, has not been collected.

Table 36: Number of clients being case managed

	Case management (MHCP)		Case conferences		Case discussions	
	Females	Males	Females	Males	Females	Males
Jul – Sep 10	19	3	1	2	57	39
Oct – Dec 10	0	0	6	0	12	10
Jan – Mar 11	0	0	15	4	195	86
Apr – Jun 11	26	4	11	4	80	61
Jul – Sept 11	19	3	1	2	57	39
Oct – Dec 11	13	6	14	3	32	26

Table 36 (page 96) presents the number of *new* clients being case managed each quarter. The case management of clients occurs with many agencies, including but not limited to NT Department of Children and Families (DCF) and NT Department of Housing. The fluctuations and differences between quarters is not necessarily an indication of differences in the number of clients being case managed, rather it is most likely a reflection of staff changes, and the number of staff available during that quarter. A system to document the total number of clients being case managed at any one time is required for further detail regarding this indicator.

Table 37: CRG Attendance by partners

Partners	11-Feb-10	24-Mar-10	05-May-10	16-Jun-10	28-Jul-10	08-Sep-10	20-Oct-10	01-Dec-10	27-Feb-11	20-Apr-11	08-Jun-11	24-Aug-11	23-Nov-11	22-Feb-12	02-May-12	23-May-12	Total (%)
SSSS PROGRAM GOVERNANCE																	
CAAC – Management			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		13 (81)
CAAC – SSSS	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	14 (88)
ALICE SPRINGS AOD SECTOR																	
ADSCA	✓	✓			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13 (81)
CAAAPU	✓				✓		✓	✓			✓	✓		✓		✓	8 (50)
Holyoake	✓		✓	✓			✓	✓		✓	✓	✓		✓	✓	✓	11 (69)
Bushmob (Youth)	✓	✓	✓		✓	✓	✓	✓	✓			✓		✓			10 (63)
HARM MINIMISATION																	
DASA			✓		✓	✓	✓		✓				✓	✓		✓	8 (50)
Tangentyere Council	✓	✓				✓	✓		✓			✓					6 (38)
HEALTH AND FAMILIES																	
Alice Springs Hospital	✓								✓								2 (13)
CAMHS	✓	✓	✓	✓				✓	✓								6 (38)
MHACA	✓																1 (6)
JUSTICE REFERRAL SYSTEM																	
ASCC	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓				10 (63)
Northern Territory Police			✓					✓						✓			3 (19)
GOVERNMENT DEPARTMENTS																	
ASTP	✓	✓			✓	✓	✓	✓	✓			✓	✓		✓	✓	11 (69)
NT Department of Justice	✓			✓		✓	✓	✓	✓	✓	✓		✓				9 (56)
FaHCSIA		✓			✓	✓											3 (19)
Dept of Health & Ageing			✓					✓	✓								3 (19)
DCF			✓			✓		✓					✓			✓	5 (31)
NT Department of Corrections		✓		✓													2 (13)
Total no. of agencies	12	9	10	7	9	10	11	12	11	4	6	9	8	8	5	7	

* See Table 1 (page 6) for explanation of the abbreviations used in this table

6.1.3 Participation by AOD sector members in CRG meetings

The SSSS has two advisory committees, the Coordination Reference Group (CRG) and the Evaluation Steering Group (ESG). These are presented in Figure 8 (page 121). The CRG are tasked with overseeing the operations and implementation of the *Safe and Sober Support Service* program, while the ESG is responsible for advising on the evaluation of SSSS. The terms of reference for the CRG are detailed in Appendices (page 124). The terms of reference identify the 15 member agencies of the CRG, including 13 the representatives. It should be noted that of the 13 representatives, nine have changed positions and are no longer with those agencies, and a tenth member handed membership to a colleague who has also resigned from her position. It is important to note that 77% of the CRG committee has changed since the establishment of the SSSS.

The CRG met every six weeks from February 2010, with each meeting alternating between discussion of SSSS implementation and the reporting against the process evaluation. With the program established, from June 2011 the meetings frequency was reduced to once a quarter. The attendance and participation in CRG meetings is an indicator of the program, this information is provided by the minutes of the meetings. The attendance at the CRG meetings has been outlined in Table 37 (page 97). Since February 2010, there were 16 CRG meetings. The attendance of each agency ranged from one to 14 meetings, the overall average attendance were seven meetings per agency. The SSSS manager and CAAC management attended 88% of meetings, while ADSCA attended 81% of meetings. In addition to the 15 original CRG members, another four government departments also attended the meetings. Between four and twelve agencies were represented at each meeting, with an average of eight agencies attending each meeting. The final CRG meeting was held on the 23rd of May 2012.

6.1.4 Thematic analysis of program documentation [meeting minutes]

The CRG meetings served a number of roles, as outlined in the terms of reference (page 124). A review of the meeting minutes shows that most of the meetings are focused on the review of the SSSS quarterly and six-monthly reports. There has been little, if any, *exchange* of quantitative and qualitative data and information about service provision of partner service providers; all data provided in the meetings have been provided by SSSS. The CRG is a valuable opportunity to examine service utilisation and engagement across the AOD-sector, perhaps more effort should be placed to undertake this. The CRG is an important opportunity for agencies to come together regularly; however, the change in 60% of representatives has led to a different focus. These meetings are often immediately following an alcohol interagency meeting, with similar attendees, some of the information and discussion is duplicated for those that do not attend the other meeting.

As one key stakeholder stated that, the CRG was vital to the establishment of the Program. Now that SSSS is established, the focus and terms of reference the CRG should be re-considered. A reassessment of the function of the CRG, especially how the CRG can be

used to support and encourage the engagement of the AOD (and wider) sector in Alice Springs. The CRG is an opportunity for the Alice Springs AOD-sector to assess and discuss ways collaborations can be developed and improved.

6.1.5 Establishment of formal collaboration [service] agreements between agencies

This indicator was identified to ensure that interactions with other services were clarified, and purposeful, as in 2010, there were a number of inter-agency collaborations without a clear purpose. These collaborations ended in 2011, since then no formal agreements were arranged between SSSS and other services. One of the reasons for the recommendation of the formalisation of agreements was to address the confusion surrounding the purpose and responsibilities of SSSS. Many aspects of the SSSS were 'pulled back' in early 2011, in order to consolidate the core function of the Program. As part of this effort was placed on formalising the referral process, leading to more appropriate referrals and improved interactions with other agencies. Now that the SSSS is established and operating at full capacity, efforts should now focus on establishing formal agreements with other agencies and service providers.

6.1.6 Semi-structured interviews with key stakeholders and program partners & the thematic analysis of semi-structured interviews with key stakeholders and program partners

As discussed in Data sources (page 13) the evaluator conducted semi-structured interviews with representatives from many of the SSSS partners including CRG members, AOD services in Alice Springs, government departments, social services, and training agencies. Most of the discussions and interviews were specifically regarding the interactions and relationship between the agency and SSSS, and the wider issues with the wider AOD sector in Alice Springs. Those agencies that were frequent referrers in 2010, noticed the change in accessibility in 2011. During 2010, the SSSS referral procedures were very liberal, which meant that SSSS staff spent a lot of time trying to locate referred clients; that were not willing to engage and often were not aware that SSSS would be contacting them. The 2011 referral processes reduced this by ensuring that clients gave permission for referral. Despite the improvements in referrals, referring agencies expressed frustration at not hearing the outcome of these referrals. This communication is important for both agencies.

There were recommendations from a number of partner agencies regarding ways SSSS could interact and relate to other agencies. These suggestions varied, but predominantly stated that faster or immediate responses and processing of referrals were needed. Presently the Program processes and delegate referrals twice a week; however, by the time the staff attempt to contact the client, the 'window of opportunity' has closed. If referrals were processed earlier, these clients may be more likely to engage with the Program.

Another agency suggested that there be greater communication and collaboration with other CAAC departments and services. There are a variety of services and programs being offered by CAAC, these could be improved and strengthened by increased collaboration and strategic planning. It was widely acknowledged that SSSS program has a valuable and scarce skill set in Alice Springs, and that these skills could be utilised to build capacity within the AOD sector. As the SSSS was being established and the model refined, there was minimal thought given to the capacity building in the AOD sector. In addition to program collaborations, some agencies or departments made suggestions such as SSSS therapists providing training to their staff in therapies such as narrative therapy.

Another agency discussed the value of the SSSS, and highlighted that the program is only available for Aboriginal people in Alice Springs, but is also needed for non-Aboriginal in Alice Springs. This comment reflects both support of the model by the AOD sector and the wider need of the program in Alice Springs.

As mentioned previously, there were many suggestions for interagency collaboration; however, these were with the evaluator, and not the *Safe and Sober Support Service*. The most common discussion with key stakeholders was how SSSS could be improved, and collaborate with their services. There were many opportunities including joint bush trips, providing education sessions to transitional residential clients, and collaboration with mental health services. These discussions should be undertaken with the manager of SSSS, perhaps this is a possible direction and role of the CRG.

The frequent turnover of staff in services and government departments in Alice Springs is another key consideration in improving AOD sector support and engagement. The change of staff requires constant and regular communication between SSSS and other agencies. The establishment of network is important to case management, and service provision. Proactive measures should be taken at both a management and a worker level. This will reduce misunderstanding of the role of SSSS, and ensure better case management, and opportunistic collaborations.

6.1.7 Thematic analysis of semi-structured interviews with community members [Community focus group]

It was not possible to conduct a specific focus group with community members; however, individual interviews were conducted with various members of the community. These interviews have contributed to the discussion of the performance indicators in this section.

6.2 Improve and build capacity within wider AOD sector [external]

Performance indicators

This objective focuses on the efforts and contribution SSSS have made to improve and build capacity within the AOD sector in Alice Springs. SSSS has spent most of 2011 establishing the SSSS, and thus has mostly been focussed on internal rather than external

capacity building. The following performance indicators and measures will indicate the achievement of this objective:

- number and type of AOD training courses offered, and level of participation;
- number of group self-help sessions with other service providers provided and the number of clients who participate; and,
- thematic analysis of program documentation [training related].

6.2.1 Number and type of AOD training courses offered, and level of participation

The SSSS staff have participated in a number of training courses, these are outlined in Table 34 (page 87). Since 2010, SSSS have organised and facilitated three sector-wide training opportunities: two SMART RECOVERY facilitator training courses, and AIMHI training. The AIMHI training had about 22 participants; including the entire staff SSSS at the time. The SSSS staff also participated in a number of sector-wide training courses; these are discussed in another performance indicator (page 85). It should also be noted that the NT Department of Health's Alcohol And Other Drugs Program (AODP), have contracted Turning Point, a Victoria AOD agency to provide training relevant to the sector in Alice Springs. The provision of the AOD training by Turning Point has reduced the need and expectation for SSSS to organise and facilitate training.

6.2.2 Number of group self-help sessions with other service providers provided and the number of clients who participate

As part of the original Program design, SSSS was to provide self-help group sessions with other service providers. During 2010, SSSS provided a number of group sessions in other agencies. Each group session, offered once a week, was the responsibility of one staff member, and was not provided if that staff member were unavailable. Each group had different purpose and target group. These groups were not directly comparable, as they each have different target groups. Other than the CRG, there were no agreements about the roles of each agency, and the strategic purpose of providing the groups with other agencies. No clear data was made available to the evaluators regarding participation and individual group sessions, most likely because minimal or no data was collected.

Here is a brief description of inter-agency projects that were provided by SSSS from early 2010 until April 2011.

CAAAPU

This group, at Central Australian Aboriginal Alcohol Programs Unit (CAAAPU), was a continuation of a *GrogMob* group. An Aboriginal AOD worker faciliatated the group session and a small number of female residents; later a therapist also attended and introduced a structured program. The sessions provided AOD and health education. The women are clients of CAAAPU treatment program, and were not clients of the SSSS prior to their admission. During the program, there were a number of issues, including the

prevention of therapists in attending the sessions. It was recommended that there be a clear agreement between both agencies, to clarify the purpose of the group and assist with the collaboration. The group ceased in March 2011.

Clontarf Football Academy and Centralian Senior College

In October 2010, the SSSS team began working with Clontarf Football Academy and senior girls program at Centralian Senior College. These sessions were a commitment for at least two staff per group, each week. As of November 2010, there was no clear program or agreement for the sessions. These sessions were education/prevention focused; the role of SSSS in the provision of the sessions required consideration. These groups ceased in January 2011.

DASA including Aranda House

From early 2010, two SSSS workers visited the DASA sobering-up shelter on Tuesday and Wednesday mornings. During these visits, the SSSS workers provided brief interventions to clients as they left the shelter, and informed them of the program. This was very time consuming for the staff, due to the early start. The outcomes from this are not clear; however, self-referrals from this contact have occurred. The early morning visits to the shelter ceased in April 2011, as it required staff to start before they were contractually required to.

From 2010 a SSSS therapist visited Aranda House, the residential rehabilitation program operated by DASA. This group was a continuation of a group provided by *GrogMob*. The weekly group provided brief interventions and AOD education to DASA clients; this was described as an 'engagement strategy'. The program ceased in December 2010 with the resignation of the therapist facilitating the group.

Irrekerlantye

The *Irrkerlantye* program was originally a family therapy group; an AOD therapist worked with the children, and an AOD worker worked with the parents. By November 2010, there had been no work done with the parents. However, group sessions with the children were conducted twice a week, entirely by a particular therapist. This group ceased with the resignation of the therapist in April 2011.

6.2.3 Thematic analysis of program documentation [training related]

There is no training documentation to review.

6.3 Discussion

The third aspect of the SSSS is the wider engagement and partnership of the AOD-sector and social services in Alice Springs, with the purpose of increasing inter-agency collaboration, decreasing the duplication of services, and filling the gaps in service needs.

The objectives of establishing a well-supported interagency AOD network in Alice Springs; and, improve and build capacity within wider AOD sector have been achieved.

The AOD network has been established, as indicated through the achievement of a number of the performance indicators. The number of referrals from other agencies is one indicator of the engagement with other agencies in Alice Springs. There are new sources of referrals every quarter. The number of referrals was much smaller than originally expected. The agencies that SSSS receive referrals from are not all CRG members, and a number of the CRG members do not refer clients to SSSS. Consideration should be given as to how SSSS can support and engage with these partners, to improve collaboration and service collaboration in the future.

Another aspect of establishing a well-supported AOD network has been the CRG. A review of the CRG terms of reference highlights that only some aspects have been implemented, while others are yet to be. The SSSS, and other agencies, have benefited from the CRG, however the future role and purpose of the CRG should be re-considered and reviewed. There is a need for the AOD-sector to come together regularly, however a more equitable platform and the inclusion of other social services may be of greater benefit to the sector.

The reporting and monitoring of case management of clients within the current system is difficult. To assess and report on the extent of the interagency collaboration, SSSS should consider the recording of referrals from SSSS. This could provide a quasi-indication of the interagency collaboration, and a clearer identification of the wider network SSSS have developed.

The SSSS have also contributed to the improvement and capacity building of the AOD-sector in Alice Springs. As it is not the primary responsibility of SSSS to build the capacity of the sector, the efforts made by SSSS are adequate. It must also be noted that the internal capacity building of the program is also developing the capacity of the sector as most of the AOD workers are new to the sector in Alice Springs, and the therapists were mainly recruited from interstate.

Many of the original performance indicators for this section are not necessarily the responsibility or in the control of the SSSS (for example: Participation by AOD sector members in CRG meetings), or are an ambitious task while establishing a Program (Number of group self-help sessions with other service providers provided and the number of clients who participate). Consideration should be given to achievable and relevant performance indicators for SSSS; in particular for those that are within the scope and responsibility of SSSS.

Recommendations

It is recommended that consideration be given to:

1. engaging and collaborating with non-CRG referral sources, to improve service provision.

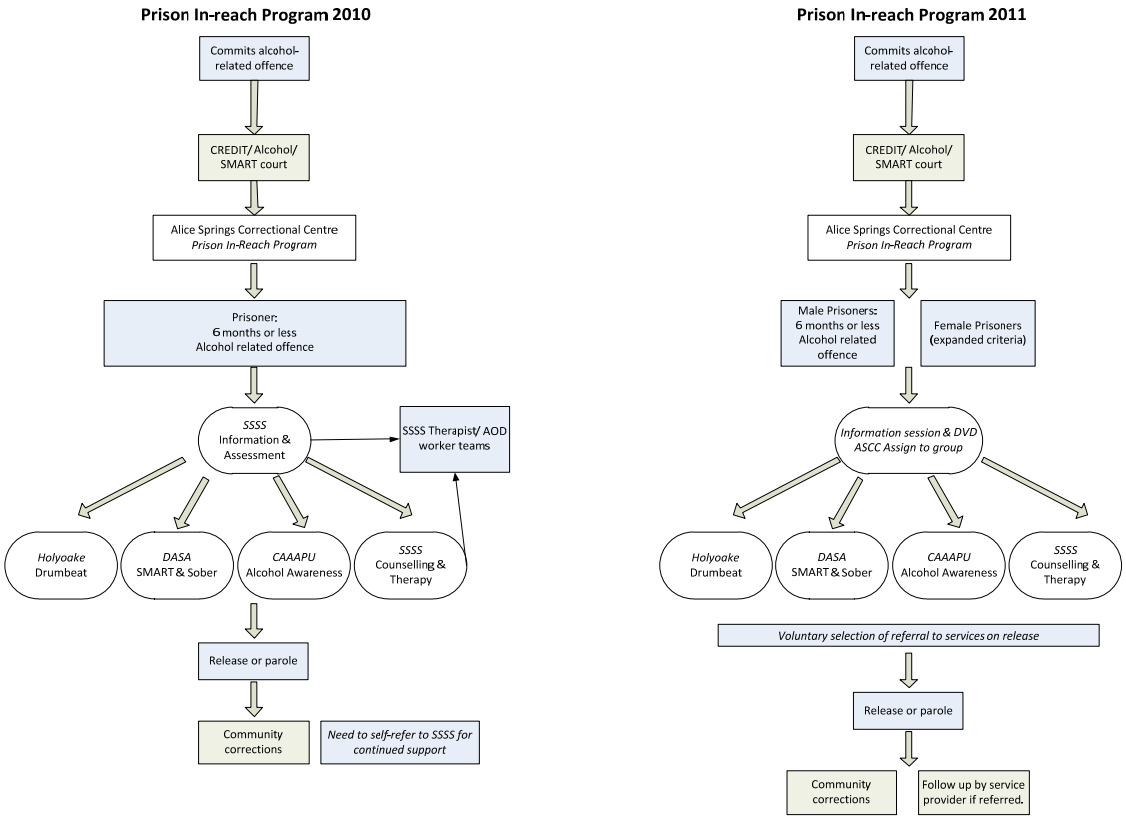
2. recording external referrals from SSSS, and the extent of the case management of clients.
3. reassessing of the role and function of the CRG, especially as to how the CRG can be used to support and encourage the engagement of the AOD (and wider) sector in Alice Springs. This should include a review of the CRG terms of reference.
4. reviewing the performance indicators and objectives of the AOD-Sector Support and Engagement and that these are aligned with the purpose of the SSSS.

7 Prison In-reach Program

7.1 Prison In-reach Program Model

The Prison In-Reach Program (PIRP) is a collaborative Program provided in Alice Springs Correctional Centre (ASCC) by four non-government AOD service providers – SSSS, Holyoake, DASA, and CAAAPU – in Alice Springs. Each of these service providers offer group courses to eligible prisoners in ASCC with sentences of six months or less, for alcohol-related offences. Unlike the rest of the SSSS, the PIRP is not only for Aboriginal prisoners, it is open to all eligible prisoners. Participation in the PIRP is voluntary; participants may elect to participate in one or more of the courses. The Northern Territory Government's Department of Health, Alcohol and Other Drugs Program funds services each week for two staff at 0.2 FTE. The original design of the PIRP was to provide each course for two hours once a week, to the male prisoners in the morning, and the females prisoners in the afternoon. It must be noted that each of the courses provided under the PIRP are unique and not comparable.

Figure 6: Prison-In Reach Program Model



The PIRP operated in two forms, both of these models are presented in Figure 6; adjustments were made to the operation of the Program in early 2011. The PIRP courses began in June 2010, with the aim of reducing recidivist behaviour related to criminal

alcohol use for the eligible cohort. The PIRP operated as originally conceptualised until December 2010. During this time, most of the participating agencies, including the ASCC, had a change in staff; this affected the way the PIRP was operating and the expectations of the Program, as each agency had a different interpretation of the way the program was to operate. The original plan was that the ASCC would identify eligible participants, for a weekly information and briefing session. Two SSSS staff would attend the briefing session outlining each of the options for the participants, and when appropriate they would conduct the initial assessment of clients. If interested participants would then elect to participate in one or more of the available courses. One of the greatest barriers to the PIRP in this form was that SSSS did not have access to prisoner names and the length of sentences. The ASCC had to provide the names to SSSS; who then had to provide them to the other service providers; this communication pathway was often delayed and problematic.

The 2010 PIRP offered limited courses for female prisoners, with only the SSSS case management and Holyoake's DRUMBEAT providing courses to this client group. The reason other agencies were not offering courses to the female prisoners was that there were less female prisoners and thus fewer participants eligible for the PIRP. In addition to this, because of the smaller numbers of female clients, the courses for female prisoners were more likely to be lockdown or cut short in situations of staff shortages; thus making the provision of the PIRP groups to female clients difficult and problematic.

Due to issues within the ASCC and staffing, the PIRP was not offered from January to June 2011. During the hiatus, the PIRP was refined and refocused. The PIRP recommenced in late June 2011, with four main changes. Firstly, the assessment and information sessions were no longer provided by SSSS, rather a DVD about each available course was shown so that the clients had a consistent message about each available course. Holyoake did not participate in this DVD, as they decided to use the Holyoake-developed DVD about Drumbeat. This DVD was created with the partner agencies, by another Indigenous-specific AOD youth program, *Bushmob*. Secondly, there were clearer communication pathways and responsibilities with the ASCC and services, the reliance on SSSS to provide the group lists ceased, and the ASCC provided the relevant lists to each agency. This addressed one of the key issues of the 2010 PIRP. Thirdly, the PIRP service providers acknowledged and agreed that the focus and purpose of the PIRP was to provide participants with life skills and opportunities with service providers on their release. Given this, processes were established so that at the completion of each course participants could identify agencies that they wished to be referred to on release. Fourthly, because of the limited access to the female prisoners, the PIRP service sought an amendment to the PIRP criteria for the female clients; approval was received in November 2011, to enable all courses to be available to all female prisoners on a rotational basis. Due to limited staffing in all partner agencies, the 2012 courses were scheduled to recommence in February.

Figure 7 provides an outline of the major events and changes to the Prison In-Reach Program as previously discussed, and an indication of the courses provided.

Figure 7: Prison-In Reach Program Timeline of key events and changes

		AAP	Drumbeat		SAS	Case management	
		M	M	F	M	M	F
Jan 2010	Program in development and negotiation with all partners. All agencies participated in SMART RECOVERY training. SSSS provide introduction and information sessions to both men and women.						
Feb							
Mar							
Apr							
May							
Jun	PIRP begins in ASCC.						
Jul							
Aug							
Sept							
Oct							
Nov							
Dec							
Jan 2011	PIRP in hiatus. Data collection templates recommended. The program is re-designed. Includes the decision for SSSS to cease the information sessions. BushMob develop an introductory DVD for the information session.						
Feb							
Mar							
Apr							
May							
Jun	PIRP 2011 begins. Providers focus on providing the PIRP courses to male prisoners. Referral on-release forms introduced.						
Jul	Drumbeat recommences.						
Aug							
Sept	SSSS begin providing counselling to female clients.						
Oct							
Nov							
Dec							
Jan 2012	PIRP programs provided to female prisoners on rotation basis.						
Feb							
Mar							
Apr							
May							
Jun							

7.2 Results: Prison In-Reach Program

Objectives

There are two objectives for the PIRP: the provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre (ASCC); and, a reduction in the levels of recidivism for prisoners who engage with SSSS (reported on annually). As discussed on page 17, there are a number of data sources used to evaluate the achievement of these objectives, these include attendance data from PIRP service providers, interviews with course facilitators, and others working with the PIRP in the ASCC.

7.2.1 Provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre

Performance indicators

Five performance indicators will indicate the provision of consistent evidence-based alcohol-related education programs to prisoners in Alice Springs Correctional Centre:

- number of alcohol rehabilitation program sessions delivered in ASCC;
- number of clients engaging in and completing each alcohol rehabilitation program in prison;
- number of PIRP clients who contact and engage with SSSS following release from ASCC; and,
- thematic analysis of reports from participating service providers; and,
- semi-structured interviews with Prison In-reach Program partners and key stakeholders.

7.2.2 Number of alcohol rehabilitation program sessions delivered in ascc

7.2.3 Number of clients engaging in (and completing) each alcohol rehabilitation program in prison

The PIRP courses commenced in the ASCC in June 2010, following a hiatus between January and June 2011, the PIRP courses recommenced in June 2011. Table 38 (page 110) details the PIRP courses provided, and the number of prisoners participating and completing each course. In total 19 courses were provided under the PIRP, with 198 individuals enrolling, and 127 completing all sessions of the courses in which they enrolled.

Alcohol Awareness Program (AAP)

Central Australian Aboriginal Alcohol Programs Unit (CAAAPU), an Aboriginal non-government organisation, provides a four-session Alcohol Awareness Program (AAP). The aim of the course is 'To increase participant's knowledge of alcohol, what are the effects of alcohol, short and long-term and what alcohol does to your body, based on new Northern Territory flipchart.'[2] The program is an information and education program, based on the *Grog – Making the Change* flipchart.[3] The AAP has two facilitators at any one time; out of three of the facilitators, two are local Aboriginal Australians. According to the facilitators,

pre-program and post-program assessments are conducted. The AAP was only provided to male prisoners.

CAAAPU ran the AAP three times in 2010, and four times in 2011. According to the data provided by CAAAPU, there were 85 participants across the seven courses, with 70 (82%) attending all four sessions.

DRUMBEAT

Holyoake, a non-Indigenous non-government AOD service, caters for both Indigenous and non-Indigenous clients, and provides *Discovering Relationships Using Music, Beliefs, Emotions, Attitudes & Thoughts* (Drumbeat). Drumbeat, a ten-session structured course that utilises drumming as a tool for cognitive behavioural therapy, is not alcohol-specific; rather it focuses on social issues such as: dealing with emotions, identity and social responsibility.[10] The course is closed, that is participants are required to commit for all ten sessions.

Drumbeat has been evaluated[11–13]; with a recent evaluation of the implementation of the course as part of the PIRP in ASCC being released in mid-2011.[14] The evaluation claims positive outcomes for the participants however it does not assess the outcomes for participants in relation to their alcohol use. The course has two facilitators at any one time; all three trained facilitators are non-Indigenous. Holyoake have been conducting pre-course and post-course assessments.

Drumbeat was provided to both male and female prisoners in 2010; however was only offered to male prisoners in 2011. Holyoake provided six 10-session Drumbeat courses in the ASCC. In 2010, two courses were provided to both the male and female prisoners. Two courses were offered in 2011 to the male prisoners. According to the data provided, Drumbeat had 52 participants, with 28 (54%) completing all sessions of the course.

Safe and Smart (SAS)

Drug and Alcohol Services Association of Alice Springs (DASA), a non-Indigenous non-government AOD service, provides a six-session modified version of *Self Management And Recovery Training* or SMART RECOVERY.[8] SMART RECOVERY is a self-help group that also uses the principles of Cognitive Behavioural Therapy to assist people to manage their thoughts and actions, through problem solving skills.[2.] Each session is 90-minutes, and the courses are open to all participants at any point. The modifications to SMART RECOVERY for the client groups have not been documented. However, according to the DASA staff, since participants are not consuming alcohol while in ASCC, the focus has been changed to helping participants develop coping and management skills for release from ASCC.

Table 38: Number of prisoners participating and completing by PIRP courses, 2010 – 2011

Courses			Number of participants	
			Started	Completed
Alcohol Awareness Program				
	2010	June	11	11
		August	8	7
		November	12	5
	2011	June	15	15
		August	14	14
		October	10	9
		November	15	9
Holyoake DRUMBEAT				
	2010	July – September (female)	7	2
		July – September (male)	9	4
		September – December (female)	7	0
		September – December (male)	8	5
	2011	July – October	11	8
		October – December	10	9
DASA Safe and Smart				
	2010	June – August	8	0
		August – October	9	1
		October – December	12	7
	2011	June – August	11	6
		August – October	9	7
		November – December	12	8
SSSS Case Management			Clients	Sessions
2010		Info sessions (female)	43	2
		Info sessions (male)	277	5
		Counselling/ case management (female)	1	ND
		Counselling/ case management (male)	10	ND
2011		Counselling/ case management: September (female)	11	11
		Counselling/ case management: Oct – Dec (female)	15	47

During week one, the participants identify the topics they wish to discuss over the coming weeks, the most popular are presented. Topics include: anger management, relapse prevention, family violence, alcohol awareness, healthy lifestyle choices, cycle of reoffending, and developing self-confidence. An additional adjustment to the course has been to manage the diversity of language groups and English literacy. Three facilitators provide the courses; two are non-Indigenous while the third is Aboriginal. SAS has been provided to the male prisoners three times in 2010 and 2011. According to the data

provided, 61 participants have enrolled in the course, with 29 (48%) attending all sessions. Many of those not completing the courses were absent due to early parole, illness, or were sent on work parties.

SSSS *Information session/Case Management*

The original PIRP model, required the SSSS staff to conduct assessments and information sessions on Mondays with eligible prisoners, informing them of the courses that are available. The main objective of SSSS is to provide a 'multidisciplinary casework service to referred clients currently residing in ASCC. An AOD therapist and Aboriginal AOD worker co-attend sessions, with capacity to see the same and/or different clients, and to co-present Information sessions. In 2010, the responsibility within SSSS lay with one therapist who resigned in December 2010. The 2011 PIRP now has two female therapists providing therapy and case management on a regular basis with female prisoners.

According to the data available, SSSS provided the information sessions from June to December 2010; five sessions were provided to 277 male prisoners and two sessions to 43 female prisoners. The information sessions were no longer the responsibility of SSSS in 2011. Counselling or case management was provided to one female and ten male prisoners, no data are available about the number of sessions for each client. In 2011, the counselling and case management were provided only to the female prisoners, 11 clients in September; between October and December, 15 clients participated in 47 counselling sessions. There are no data as to the average number of sessions per client. This is the only aspect of the PIRP accessible to female prisoners in 2011.

7.2.4 Thematic analysis of reports from participating service providers & semi-structured interviews with Prison In-reach Program partners and key stakeholders

As mentioned previously, reports from the PIRP service providers were to be reviewed for the contextual information regarding the provision of the PIRP courses. Only one service provider provided information of use. The information from reports and the interviews with key informants will be used in the discussion (page 113).

7.3 Reduction in the levels of recidivism for prisoners who engage with SSSS

Performance indicators

One performance indicator, the quantitative analysis of alcohol-related offences and imprisonment rates in Alice Springs/ Central Australia, indicates the reduction in the levels of recidivism for prisoners who engage with SSSS.

7.3.1 Quantitative analysis of alcohol-related offences and imprisonment rates in Alice Springs/ Central Australia

This is an original performance indicator; however, this indicator cannot be assessed. Firstly, there is a delay on the availability of data; presently the 2011 data are not available. Secondly, the numbers of clients participating in the PIRP was relatively small (91 in 2010; 107 in 2011) it is unlikely that this will affect the number of offences and the imprisonment rates for Alice Springs. Thirdly, the focus on the PIRP is to provide participants with skills and following their release from prison, this too is unlikely to have had a noticeable impact on the number of alcohol-related offences and imprisonment rates. The assessment and evaluation of the PIRP is limited. Firstly, client information is managed between ASCC and the individual service provider. It was acknowledged that given the type of courses provided by the PIRP and the capacity of the courses, it is unlikely to have a noticeable short-term impact on the incarceration rates in ASCC for alcohol-related crimes. One suggestion was to track the clients who have participated in any of the PIRP courses and determine if they have reoffended; this however is problematic ethically and would require support from a number of departments and permission from all individuals. The change in the focus of the PIRP to providing opportunities for clients to be referred on release from ASCC resulted in the addition of a further indicator: the number of clients seeking to be referred to and engaging with SSSS (and other agencies) on release from ASCC.

An alternative performance indicator was suggested, the *Number of PIRP clients engaging with AOD-services following release from ASCC*. The inclusion of this indicator requires the consideration of two factors for the indicator to be useful. Firstly, the agreement to provide the additional information from all partner agencies is vital. Secondly, each agency would be required to implement a process to ensure that PIRP clients are identified when they engage with agencies outside of the ASCC. This indicator would provide an indication of the success of the refocused purpose of the PIRP; however, no data has been provided or collected by agencies. SSSS has had just one referral from the ASCC; the other PIRP service providers are unable to give an indication of the number of clients referred to their services following release from ASCC.

As part of the refocusing of the PIRP, referral forms were created to enable clients to be referred to external agencies, including PIRP service providers, on release from ASCC. However, not all PIRP service providers were using the referral forms. Even when the referrals are completed, these forms were provided to ASCC for actioning, but data were not provided to the evaluators. The course facilitators are not able to provide this information either, as in two agencies they have limited contact with the other departments thus were unaware if any clients accessing other departments. An additional factor has not been considered, according to the PIRP facilitators, most of the participants are from communities and towns outside of Alice Springs. Following their release from ASCC it is unlikely that these participants would wish to engage in programs in Alice Springs if their

intension is to reside elsewhere. To date no data are available on engagement post release, nor the demographics of those participating in the PIRP.

7.4 Discussion

Overall, the PIRP is now established and has a clear direction, with many of the previous issues addressed. According to the course facilitators, very few participants choose to withdraw from the courses in 2011. There are a number of reasons clients are not completing the entire course, these included: early release, release on work parties, or illness. The ASCC implemented procedures to address this; however, there are still incidents where participants were sent on work parties rather than attending their courses. Other barriers faced by the PIRP providers include the postponement of sessions due to the ASCC being in lock-down. According to the course facilitators, the 2011 changes to the PIRP have improved their ability to provide the courses, and addressed many of the issues facing the PIRP in 2010.

The PIRP facilitators were very reliant on staff in the ASCC to collate the participant lists, assign participants to groups, and organise groups to occur. One staff member is required to prepare the participant lists for the PIRP facilitators, if this ASCC staff member is absent, there needs to be procedures in place to ensure that the PIRP courses can still be provided. The PIRP operates with a lot of in-kind resourcing and support from the staff of the ASCC; though greatly beneficial to the ASCC this is a risk to the PIRP. The hiatus of the PIRP in early 2011 is an example of the need for the support and co-operation of the ASCC in the provision of the PIRP; without the co-operation of the ASCC the PIRP cannot operate.

Individual contracts

One noticeable barrier to a more effective PIRP, is that each of the partner agencies have individual contracts with the NTDHF, and they operate very independently of other courses. The independence of each of these partners means that the PIRP is fragmented, essentially four programs are being provided in the ASCC with management meeting occasionally – and little if any contact between the course facilitators. As mentioned previously, it is clear that most organisations focused on their own course, with little acknowledgement of the wider PIRP to which they belong, and the clients; this was also confirmed by one key stakeholder:

> *There is a very clear ownership of clients by each program. This is often not about what is best for the clients.*

Most of the course facilitators noted that they do not know much about the other courses or facilitators, and discussed the value of meeting with other facilitators. There appears to be a lot of concern from all PIRP partners that other agencies are not undertaking their responsibilities to the PIRP. Some of the co-ordination of the PIRP is the responsibility of the manager of SSSS; however, the service providers are not obligated to respond, nor are they required to participate in the meetings. One such example of this individuality has

been the introduction of the forms for referrals on release from ASCC; these forms have been introduced, but only one PIRP service provider is using them.

There are a number of ways that the individualism can be addressed at managerial and facilitation level. Firstly, consideration should be given to one service provider co-ordinating the PIRP, including the 'contracting' of each service provider. This would create an increased level of accountability and consistency across the entire Program. One point of contact could assist in the sharing of data, and the coordination of services for clients post-release. In addition, as previously mentioned some of the course facilitators identified the desire to meet regularly with the other PIRP course facilitators, they felt that sharing their experiences could improve course provision, and the provision of the PIRP.

The individual contracts, as previously mentioned, restrict the ability to evaluate the PIRP; as there are no formal requirements for data to be shared, these limits have restricted the ability to assess and evaluate the PIRP. The lack of readily available data related to the desired outcomes of the PIRP make assessment of the PIRP difficult.

Based on the available information, the PIRP in the ASCC has been operating consistently since June 2011. There have been a number of factors influencing the provision of the PIRP, most of these were addressed with the revision of the PIRP in 2011. There are a number of elements that could improve the provision of the PIRP in ASCC. Firstly, a more cohesive PIRP would provide regular contact between the course facilitators, united and standardised approach, and clear direction. The centralisation of the PIRP would improve also improve the data available for the evaluation of the program. Secondly, as there is no way to assess the outcomes of the PIRP, it is recommended that data related to the objectives of the program outcomes and impact of the PIRP are collected. In addition to this it is recommended that a comprehensive evaluation of the Prison In-Reach Program is established and conducted.

It is recommended that consideration be given to developing:

1. separate evaluation of the PIRP in ASCC. The evaluation should include the separate assessment of all courses, outcomes, and impact, if any, of the courses.
2. a more cohesive PIRP, including; regular contact between the course facilitators, united and standardised approach, and clear direction.

8 Summary and Recommendations

Central Australian Aboriginal Congress' (CAAC) *Safe and Sober Support Service* (SSSS) is a secondary treatment service in Alice Springs, Northern Territory, working in a holistic and culturally appropriate way to facilitate improved wellbeing for Aboriginal people experiencing the effects of harmful alcohol use. The overall goal of the SSSS is to:

> Provide a holistic and culturally appropriate counselling, therapeutic treatment and support service that strengthens the cultural, social and emotional wellbeing of Aboriginal people and their families.

SSSS has achieved this goal, and provided a program that has strengthened the cultural, social, and emotional wellbeing of clients and their families. There is still progress and work required to improve the program.

8.1.1 Ambulatory Case Management

The focus of SSSS is to provide an ambulatory case management service through the provision of support and advocacy, structured therapy and medical treatment. The client case mix and needs are complex: just 10% of active clients are in full-time employment, most are living with extended family, only half (51%) have permanent accommodation, and only 40% prefer to speak English. The SSSS have assisted clients with the achievement of some very significant changes in their lives. The active and engaged clients of SSSS have very complex needs; these needs need to be addressed simultaneously with the provision of the other streams of care. From the available data, it appears that the model has not been able to operate as originally conceptualised. The program also had lower than expected engagement with the medical stream because of difficulties such as accessing the CAAC clinic, and replacing the program's medical officer in July 2011.

Much of the work of the program has been focused on the support and advocacy stream, an aspect of the program that was consistently provided, despite the difficulties recruiting the therapists and medical officer. The limited access to the medical stream has led to less focus on this aspect of the program. The difficulty recruiting and retaining qualified therapists, has also contributed to less engagement with the therapeutic stream than expected. The support and advocacy stream of SSSS has been the most stable aspect of the program, and often the outcomes have been immediate, significant, and tangible; compared to the other streams of care. The combination of these factors has resulted in a significantly greater focus on the support and advocacy stream, thus reducing the possible results and outcomes from the program.

The inconsistency of data collection across the program has also hindered these reporting of these outcomes, as not all outcomes have been able to be assessed. The program has developed some positive aspects that are culturally secure and appropriate; there is much potential through the bush trips for clients to maintain sobriety and have other key outcomes. The program also has the potential to develop unique monitoring and screening

tools for this unique client group. The *Safe and Sober Support Service* has achieved this objective of improving the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program. There are a number of areas that can be further developed to improve the service provision and exhibition of the outcomes and achievements of clients.

It is recommended that consideration be given to:

1. ensuring that all streams of care are provided to clients, and identified monitoring measures are used.
2. improve the consistency of data recording and collecting, to ensure that the data accurately reflects the operation of the *Safe and Sober Support Service*.
3. ensuring that the program full-time access to a medical officer, to ensure the provision of the medical stream.
4. developing a flexible program to be delivered on bush trips, to ensure that the bush trips have clear objectives and purposes, such as the provision of group therapy.
5. developing a clear and concise tool to monitor the client outcomes of the social support and advocacy stream of the program.

8.1.2 Program Capacity Building

The building and development of the internal capacity of SSSS has improved each quarter. Consistent efforts were made to continue to build capacity of the *Safe and Sober Support Service* and the staff of the *Safe and Sober Support Service*. The stability of the Aboriginal AOD workers is a core strength of the program; however the retention of the AOD therapists is an area for improvement to be explored. Addressing both the low completion rate for the Certificate IV, and the absence of formal cultural competencies would further build the capacity of the SSSS. Overall, there has been significant effort placed on building the internal capacity of the SSSS. There are a number of changes recommended that would further develop and build the capacity of the program.

It is recommended that consideration be given to:

6. conducting regular reviews of program processes – especially regarding the inputting of data into *Communicare* – to ensure consistency across the Program.
7. review and further exploration of the factors influencing the retention of the program therapists.
8. ensuring that all staff enrolled, complete the Certificate IV within a specified timeframe.
9. formalising the *Cultural competency* training, including the exploring the external facilitation of the training.
10. introducing an *external* cultural advisor/ supervisor/ mentor for the position of the program manager.

8.1.3 AOD Sector Support and Engagement

The third aspect of the SSSS is the wider engagement and partnership of the AOD-sector and social services in Alice Springs, with the purpose of increasing inter-agency collaboration, decreasing the duplication of services, and filling the gaps in service needs. The objectives of establishing a well-supported interagency AOD network in Alice Springs; and, improving and building capacity within a wider AOD sector have been achieved.

The number of referrals, and the diversity of the sources of referrals, shows that through the CRG and the wider Alice Springs network of social services, that the SSSS is a necessary program. The CRG has provided a valuable and regular forum that held SSSS accountable to the wider-sector; however, the expected feedback from other agencies did not happen. The CRG ceased in May 2012, however, and there is a need for the AOD-sector to come together regularly on a more equitable platform, perhaps including the other social services in Alice Springs.

It is recommended that consideration be given to:

11. engaging and collaborating with non-CRG referral sources, to improve service provision.
12. recording external referrals from SSSS, and the extent of the case management of clients.
13. reassessing of the role and function of the CRG, especially as to how the CRG can be used to support and encourage the engagement of the AOD (and wider) sector in Alice Springs. This should include a review of the CRG terms of reference.
14. reviewing the performance indicators and objectives of the AOD-Sector Support and Engagement and that these are aligned with the purpose of the SSSS.

8.1.4 Prison In-reach Program (PIRP)

Overall, the PIRP is now established and has a clear direction, with many of the previous issues addressed. A close working relationship is required between all of the agencies providing courses under PIRP. The intended, or expected, outcomes of PIRP have not been able to be assessed in the evaluation. Now that the PIRP is operating consistently, and collaboratively, the next stage would be an evaluation of both process and outcome measures of each course and the entire program. In addition to the evaluation, it is also recommended that effort be made to develop a more cohesive PIRP, the present model ensures independence of all the courses, making comparison and changes difficult.

It is recommended that consideration be given to developing:

15. separate evaluation of the PIRP in ASCC. The evaluation should include the separate assessment of all courses, outcomes, and impact, if any, of the courses.
16. a more cohesive PIRP, including; regular contact between the course facilitators, united and standardised approach, and clear direction.

8.2 Future directions

In addition to the consideration of the recommendations for each sector of the program, it is also recommended that consideration be given to implementing or developing changes for the entire *Safe and Sober Support Service*.

The evaluation has assessed and identified many process related issues, which can and have improved service provision. The external evaluation of the SSSS, was valuable and still has a role, however the program would benefit from the development of research skills within the program. The development of research skills within the program would assist in the earlier identification of these process issues. For similar reasons, it is suggested that staff self-assessment, against particular performance indicators, is conducted, and then a comparison is made to the actual data as reported on *Communicare*. Even though staff are required to enter data into *Communicare*, there appears to be a large disparity. The self-assessment would remind and ultimately improve data collection.

The *Safe and Sober Support Service* is a unique service that has achieved its goal of providing a holistic and culturally appropriate service that strengthens the cultural, social, and emotional wellbeing of Aboriginal people and their families in Alice Springs. There is much potential for the program to meet the needs of the Aboriginal people in Alice Springs, some clients have had these needs have met, and others have had positive outcomes achieved. With additional time, this complex client group will achieve even greater improvements and outcomes.

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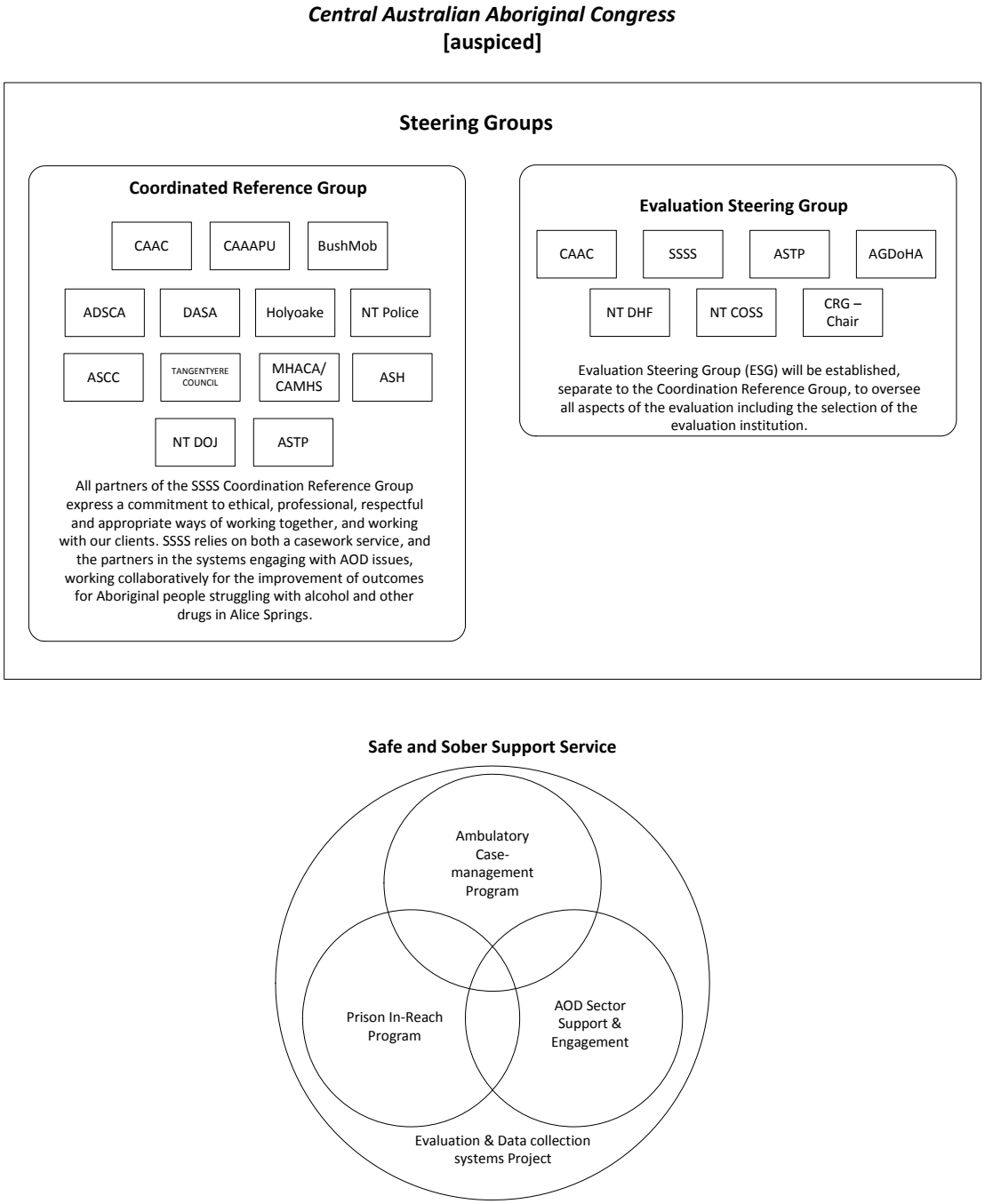
10 Appendices

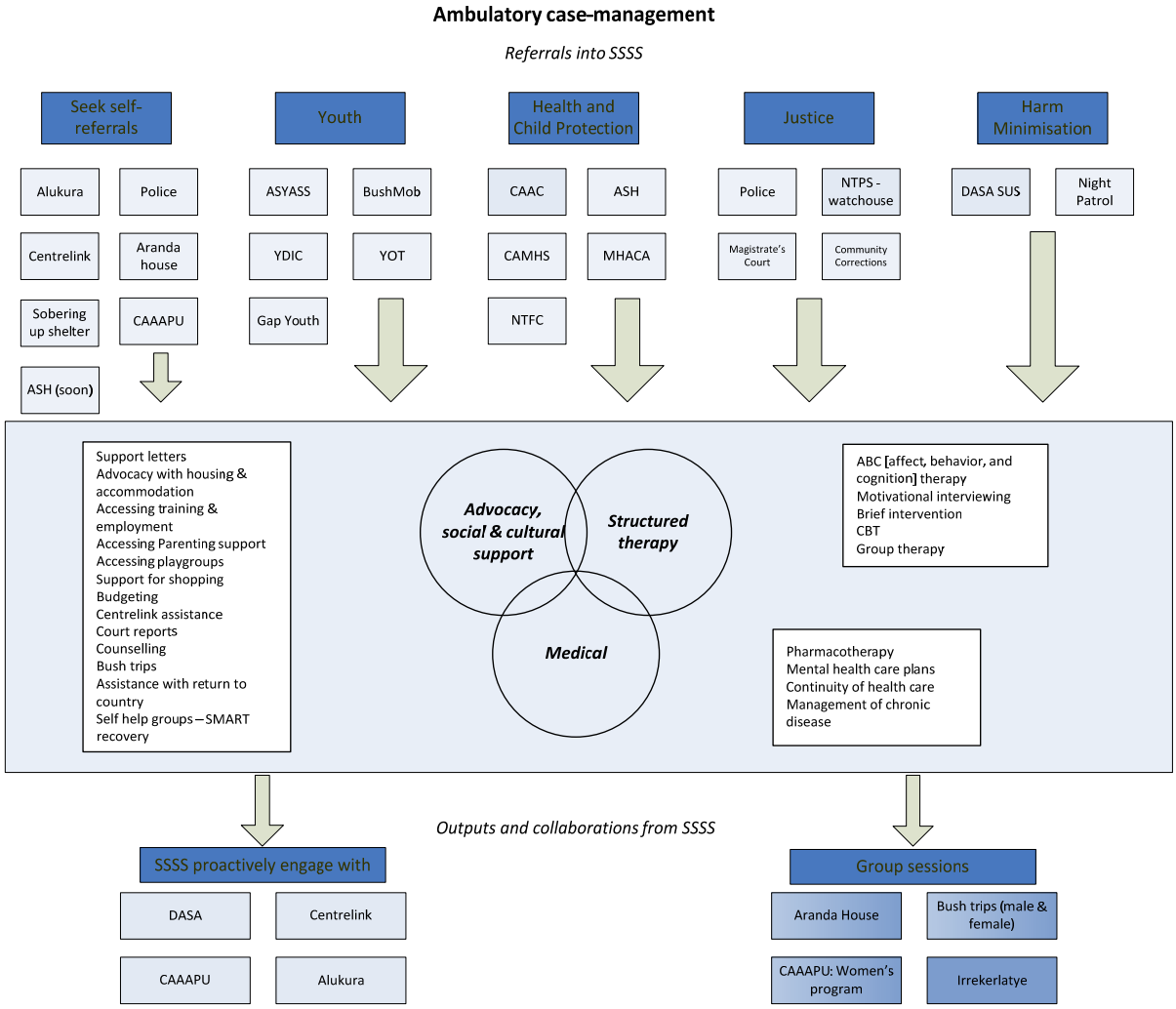
10.1 SSSS Program

Figure 8: Entire Safe and Sober Support Service



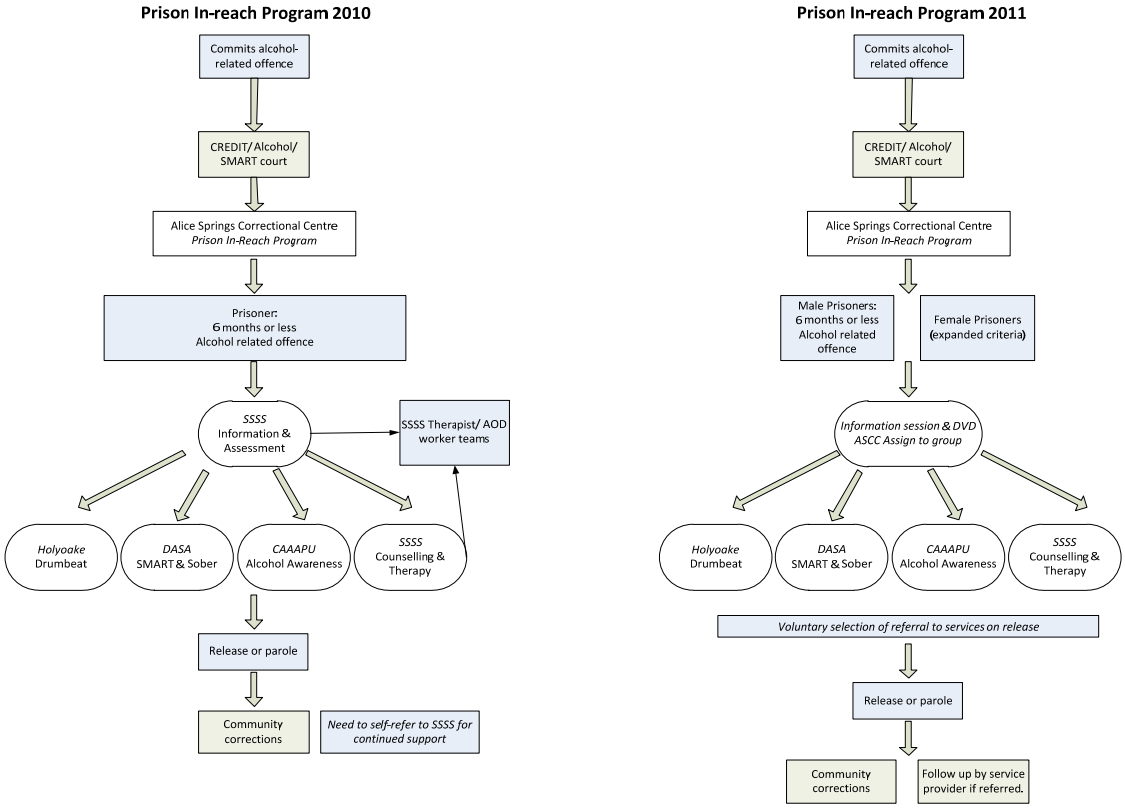
10.2 Ambulatory case-management

Figure 9: Safe and Sober Support Service – Ambulatory case-management



10.3 Prison In-reach Program

Figure 10: Safe and Sober Support Service – Prison-In Reach Program



10.4 Terms of Reference: Safe and Sober Coordination Reference Group

Preamble: All partners of the SSSS Coordination Reference Group express a commitment to ethical, professional, respectful, and appropriate ways of working together, and working with our clients. SSSS relies on both a casework service, and the partners in the systems engaging with AOD issues, working collaboratively for the improvement of outcomes for Aboriginal people struggling with alcohol and other drugs in Alice Springs.

1. **Receive and make comment** on Quarterly and Operational reports from the Programme Manager tracking progress towards service goals against key performance indicators and the Project Management Plan
2. **Exchange** quantitative and qualitative data and information about service provision of SSSS and of partner service providers, and the interface between these.
3. **Monitor** service utilisation and engagement with four referral systems.
4. **Develop** collaborative relationships between service providers and referral sources.
5. **Consider** de-identified client outcomes and use an action research approach to suggest service and sector developments to optimise client outcomes.
6. **Identify** gaps in services and barriers to achieving programme goals, for inclusion in SSSS reports.
7. **Comment** as invited on client-focused aspects of the Data system Research project
8. **Facilitate** solutions to identified problems, within the scope of this CRG, or through its member organisations
9. **Advise** CAAC Safe and Sober Program Manager on identified project implementation issues and strategies.
10. **Negotiate** change management strategies within the sector as required

Membership of CRG	**Original Members**	**Current members**
Safe and Sober Project Manager	*Tracey Spencer*	Sandra Schmidt
CAAC Directorate	John Boffa	Tony Corcoran
ADSCA	John Gaynor	
Alice Springs Correction Centre	*Peter Rainbird*	Christine Weir
Alice Springs Hospital	*Vicki Taylor*	Michael Melino
Alice Springs Transformation Plan	*Rigmor George*	Reg Hatch
Bushmob	Will MacGregor	
CAAAPU	*Abdul Khan*	
Central Australian Mental Health Services		
DASA	Paul Finlay	Paul Finlay
Department of Justice – Alcohol Strategy	*Charlie Dick*	
Holyoake	*Daphne Beattie*	Denise Brooks
Mental Health Association of Central Australia		
Northern Territory Police	*Jody Nobbs*	
Tangentyere Council	*Marg Reilly*	Sian Owen-Jones

Italics: denotes members who have resigned from that position.

10.5 Additional tables

More detailed data of Table 8: Total number of clients by age group and gender

Table 39: Total number of clients by age group and gender, by

Quarter	Gender	0–9*	10–14	15–19	20–29	30–39	40+	Total
Jan – Mar 10	F	2	1	2	18	13	19	55
	M	0	0	0	2	5	6	13
Apr – Jun 10	F	3	0	3	23	29	34	92
	M	1	0	2	8	17	25	53
Jul – Sep 10	F	3	2	5	47	50	47	154
	M	4	2	7	53	61	61	188
Oct – Dec 10	F	7	3	7	31	42	46	136
	M	6	3	5	50	42	65	171
Jan – Mar 11	F	3	7	5	35	57	63	170
	M	5	3	9	32	38	48	135
Apr – Jun 11	F	1	3	4	56	47	49	160
	M	4	1	7	22	40	44	118
Jul – Sep 11	F	0	0	3	30	46	36	115
	M	3	1	2	21	37	37	101
Oct – Dec 11	F	0	0	4	33	46	44	127
	M	0	1	5	13	35	62	116
2010	F	12	5	11	73	84	94	279
	M	10	4	11	98	98	114	335
	Total	22	9	22	171	182	208	614
2011	F	4	6	15	84	104	117	330
	M	7	4	14	56	91	118	290
	Total	11	10	29	140	195	235	620
Jan 2010 – Feb 2012	F	12	10	24	126	155	175	502
	M	13	11	20	132	159	210	545
	Total	25	21	44	258	314	385	1047

10.6 Previous recommendations

The following table outlines the recommendations made in the six-monthly reports, since December 2010.

Ambulatory Case Management

✓	February 2011	Consideration is given to examining the reasons so few AOD assessments are completed with clients and processes put in place so to address this.	This has been addressed with the improvement of program procedures and processes, and additional therapists.
✓	February 2011	Consideration is given to a system to record and document the data on all bush therapy group sessions is established.	This has been implemented.
✓	February 2011	Consideration is given to examining the reasons why so few MHCPs have been completed.	This has been implemented.
✓	February 2011	Consideration is given to examining other possible sources of income for the program are examined.	The placement of a medical officer within the program has generated *Medicare* income; however, there may be other sources of income for the program
✓	February 2011	The use of AUDIT-C is reviewed with SSSS staff; if this is not an appropriate measure, another measure must be used and implemented.	This appears to be being addressed through the improvement of program procedures and processes, and training of staff in the administering of AUDIT-C.
✓	February 2011	A system to record and document the data on all bush therapy group sessions is established.	This has been implemented.
✓	February 2011	An examination into the reasons why so few MHCPs have been completed.	This has been implemented.
✓	February 2011	Other possible sources of income for the program are examined.	The placement of a medical officer within the program has generated *Medicare* income; however, there may be other sources of income for the program
✓	February 2011	The use of AUDIT-C is reviewed with SSSS staff; if this is not an appropriate measure, another measure must be used and implemented.	This appears to be being addressed through the improvement of program procedures and processes, and training of staff in the administering of AUDIT-C.
×	February 2011	An additional measure be included, the status within the program of referred clients, to provide further detail on the program activities.	This has not yet happened; however, the priority of the program has been to improve the current program procedures and data collection processes. These measures should be considered for future reporting.
✓	August 2011	Consideration is given to the close management of the medical stream of the SSSS, during the absence of a specific medical officer.	In the absence of recruiting a medical officer for the SSSS, alternative arrangements have been put into to ensure better access to GPs in the clinic.
	February 2012	Consideration should be given to assessing of the level at which each client engages with the SSSS.	
	February 2012	Consideration should be given ensuring regular and consistent recording of data in *Communicare* occurs.	
	February 2012	Consideration should be given ensuring the SSSS program staff are trained in the use and delivery of the AUDIT-C and K5 tools.	

	February 2012	Consideration should be given separating the recording of data for the internal and external case management indicators.	
	February 2012	Consideration should be given utilising the greater potential of the bush trips; including improvements in the consistency of recording and reporting data; structured education and therapeutic programs are implemented; and the integration of SMART RECOVERY strategies is explored.	
	February 2012	Consideration should be given expanding definition of an engaged client to one that engages regularly with SSSS and with more than one stream of care.	

Prison In-reach Program

✓	February 2011	The entire PIRP be reviewed, especially in relation to its role in the wider SSSS. Consideration should be given to the: purpose of the Program; actual numbers of clients engaging in one of the courses; evaluation and assessment of outcomes for these clients; and, the future of the PIRP given the proposed changes to the Alcohol Act (2011).	Some elements achieved in June 2011; the PIRP has been re-established and issues identified previously were addressed. Further consideration is required.
×	August 2011	Consideration is given to the centralised coordination of the PIRP.	This has not yet happened.
×	August 2011	Consideration is given to the inclusion of an additional indicator: Number of PIRP clients engaging with AOD-services following release from ASCC.	This has not happened; however, efforts are being made by SSSS to record and collate this information. Other agencies need to consider similar processes.
	February 2012	Consideration should be given to developing separate evaluation of the PIRP in ASCC. The evaluation should include the separate assessment of all courses, outcomes, and impact, if any, of the courses.	
	February 2012	Consideration should be given to developing a more cohesive PIRP, including; regular contact between the course facilitators, united and standardised approach, and clear direction.	

AOD Sector Support and Engagement

✓	February 2011	The elements of required for an AOD network are considered for implementation. Such as the: formalisation of the each relationship; relationships to not just be at a management level, but to also be at an organisational, and worker level; and, complete feedback processes, including regular response to the referrer, for all referrals to SSSS; and, regular opportunity for program staff to feedback, successes and barriers, experienced while interacting with other partner agencies	This recommendation has been considered; the partnerships will be clarified once program processes and procedures are clear.
✓	February 2011	Develop clear partnership agreements with partner agencies, particularly in regard to the group sessions.	This recommendation has been considered.
×	August 2011	Consideration is given to the objectives of the CRG being reconsidered to develop and build interagency collaborations.	The reduction in the frequency of CRG meetings is an indicator that the original role of the CRG should be reconsidered.

	February 2012	Consideration should be given to how SSSS can support and engage with non-CRG referral sources, to improve service provision.	
	February 2012	Consideration should be given to reassessment of the role and function of the CRG, especially as to how the CRG can be used to support and encourage the engagement of the AOD (and wider) sector in Alice Springs. This should include a review of the CRG terms of reference.	
	February 2012	Consideration should be given to the performance indicators and objectives of the AOD-Sector Support and Engagement and that these are aligned with the purpose of the SSSS.	

Program Capacity Building

×	February 2011	SSSS staff are regularly (twice a year) reflect on the training they have participated in, to assist in identifying additional training needs.	This has not been implemented; however, this is no longer relevant as is being addressed through their individual training appraisals.
✓	February 2011	The SSSS Manager maintains a log of the training courses that SSSS participate in, as record of the program capacity building activities.	This has been implemented.
✓	February 2011	Clear program guidelines and procedures are developed for the SSSS; including consistency in recording all program activity relevant to the reporting requirements.	This has been implemented. Regular *Communicare* training is recommended with staff to ensure improved recording of program outputs.
✓	February 2011	The gender balance of the SSSS staff is considered, in the employment of additional staff; particularly in the therapist positions.	This has been addressed, however additional male therapists are still required.
✓	February 2011	Clear case management systems are developed for SSSS, including the reporting and recording of all data.	This has been implemented.
✓	August 2011	Consideration is given to the provision structured and externally facilitated group supervision for all SSSS staff.	A very experience psychologist and psycho-analyst, with more than 20 years of experience, in Indigenous AOD, has been providing external supervision.
✓	August 2011	Consideration is given to the provision of accredited training for the clinical psychologists as part of the Program.	This has happened so far, with some of the SSSS staff attending interstate conference, which are credited as professional development to retain accreditation.
	February 2012	Consideration should be given to conducting regular reviews of Program processes – especially regarding the inputting of data into *Communicare* – to ensure consistency across the Program.	
	February 2012	Consideration should be given to ensuring that all staff enrolled complete the Certificate IV, within a specified timeframe.	
	February 2012	Consideration should be given to conducting an audit of staff skillsets; resulting in an individual professional development plan for SSSS staff.	
×	February 2012	Consideration should be given to undertaking strategic planning to implement SMART RECOVERY training and establish such groups, before additional staff are undertake training.	This recommendation is no longer relevant now that SSSS have decided that is not appropriate for the client group.
	February 2012	Consideration should be given to formalising the Cultural competency training; including the exploration of it being provided externally to the Program.	