A needs analysis of alcohol related service delivery in the Katherine Region

An Aboriginal Community Controlled Approach.

2012

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<td>MI</td>
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<td>NT</td>
<td>Northern Territory</td>
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<td>NTER</td>
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<td>SIAP</td>
<td>Stongbala Intensive Alcohol Program</td>
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<td>VSM</td>
<td>Volatile Substance Misuse</td>
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**Groups and Committee’s**

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<td>Interagency Tasking and Coordination Group</td>
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<td>KRAG</td>
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<td>Katherine Regional Harmony Group</td>
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**Services & Organisations**

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<td>Council for Aboriginal Alcohol Program Services</td>
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<td>Center for Remote Health</td>
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<td>ED</td>
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<td>KWHB</td>
<td>Katherine West Health Board</td>
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<td>MA</td>
<td>Mission Australia</td>
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<tr>
<td>NAAJA</td>
<td>Northern Australia Aboriginal Justice Agency</td>
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<td>NTCCS</td>
<td>Northern Territory Community Corrections Service</td>
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<td>PC</td>
<td>Police Custody</td>
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<td>RTC</td>
<td>Return to Country</td>
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<td>SHSAC</td>
<td>Sunrise Health Service Aboriginal Corporation</td>
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<td>Sobering Up Shelter</td>
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<td>VRC</td>
<td>Venndale Rehabilitation Centre</td>
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<td>VTER</td>
<td>Vocational Training and Education Centre</td>
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<td>VTAC</td>
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<td>WWHS</td>
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<td>YMCA</td>
<td>Young Men’s Christian Association</td>
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**Government Bodies**

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<tr>
<td>FaHCSIA</td>
<td>Department of Families Housing Community Services &amp; Indigenous Affairs</td>
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<td>NTG</td>
<td>Northern Territory Government</td>
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Executive Summary

Background

Katherine’s collective alcohol related service sector, prior to the Northern Territory Emergency Response (NTER) in 2007, consisted of a handful of specific alcohol related services and programs. Over the past decade, these have grown to include a sobering up shelter, residential rehabilitation facility and the government run alcohol and other drug program. This expansion was in part due to funding made available through the NTER (NTER Review Board 2008). The NTER mandated that prescribed Aboriginal communities be alcohol free, and this has resulted in people coming into Katherine to access the restricted but available alcohol supply. The impact on Katherine of the creation of dry communities has reportedly been considerable, with the effect of increasing demand and pressure on Katherine based treatment and support services (Origin & Bowchung Consulting 2010).

This report examines the capacity of services to cope with current demand and documents the infrastructure, services and programs that are available in Katherine and the region that are available to address alcohol and other drug (AOD) related issues. While it is recognized that proactive measures in the form of prevention programs are most important when addressing the harmful use of alcohol overall, there is a focus in this report on reactive measures in the form of treatment pathways, and this is because the objective of this report is to provide background to optimizing service delivery options.

Method

A participant action research (PAR) approach was taken where CRH personnel acted as facilitators providing advice on data collection, and documentation, and with the Healing Pathways Project Coordinator actively interacting with stakeholders with the objective of involving the stakeholders in addition to collecting and documenting data. Data was collected from all services in Katherine providing services related to the harmful use of alcohol. This was done by standardised questionnaires and followed up by semi-structured interviews. During this process stakeholders were encouraged to discuss strengths and weaknesses of their service and how they might think service delivery overall could be improved.

Current Environment

1. Infrastructure

The infrastructure available in Katherine that houses interventions for clients with AOD related problems includes the following: Venndale Rehabilitation Centre, Venndale Transitional Aftercare (VTAC), Yarralah Sobering Up Shelter (SUS), Katherine Hospital, Strongballa Men’s Health
facility, Wurli-Wurlinjang Health Service Clinic and Wellbeing Unit, Ormond House Men’s Accommodation, and the Women’s Crisis Centre.

2. Services
Katherine’s alcohol related services include Aboriginal specific Wurli-Wurlinjang AOD program that includes the Katherine Indigenous Alcohol Reference Group (KIARG), Intervention Case-Management Services (ICMS) at Mission Australia. Regionally programs are more preventative in nature and include: the Department of Health AOD program, Katherine West Health Board’s (KWHB) AOD regional program, and Sunrise Health Service Aboriginal Corporation’s (SHSAC) Tobacco Control and Other Substances Program.

3. Access to Services
Clients come into contact with AOD services by self referral, mandated or referral by another agency. However access is determined largely by the services’ capacity to accommodate them and service policy. For example there is a four to six month waiting period for the Venndale Rehabilitation Centre and children cannot be admitted, and so this precludes access by families. Transport is another limiting factor to access and while Wurli Wurlinjang Health Service (WWHS) provides transport for clients within a 30 mile radius of Katherine other clients living in communities need to find transport and then accommodation in Katherine.

Access to Regional services is limited by the few resources available. Regional services are supplied by the Department of Health (DoH) Alcohol and Other Drug Program (AODP), SHSAC in the Katherine East region, and KWHB in the Katherine West region. The AODP can travel to remote communities, but currently it has a very limited capacity to do so. Staff have identified the need to do more in supporting staff at remote locations so that the work is more sustainable and staff can continually be supported and up-skilled. Telephone counselling has been used as a method to continue support from initial consultations.

KWDB provides limited services to the communities of the Katherine West region and access to the service is determined by when the AOD program coordinator visits the communities, which is a very limited number of times a year. SHSAC has a Tobacco Control and Other Substances Program which is run by one Aboriginal mental health worker and is also limited in scope.

Service Capacity and Gaps
The review of infrastructure and respective services indicate that much of the current infrastructure is adequate to meet current needs. The exception to this is the crisis accommodation for both men and women. The men’s crisis facility, Ormond House, is severely restricted by its size and has been
constantly full for the last three years. Similarly the women’s crisis centre which has a capacity of 25 beds has been operating at full capacity for the last year. It was estimated by staff another 30 beds would be occupied given the need is so great for the service indicating that service delivery is hampered by lack of infrastructure.

In every case other than the crises centres mentioned above the limiting factor for service delivery was seen as inadequate resourcing in the area of funding and staff. All agencies identified the need for a significant boost in having specialist staff available to work with their clients. A brief summary of the capacity issues AOD services are having in Katherine are listed below:

- Wurli-Wurlinjang have reported a 340% increase in AOD service activity in the last year and highlight significant staffing shortage issues, particularly therapists and community based AOD workers that would be attached through Katherine Indigenous Alcohol Reference Group;
- Department of Health highlight the need for more resources in regional areas with particular relevance to mental health, AOD and working with youth;
- ICMS are limited by operational hours and staffing to provide more formal case-management outreach work;
- KWHB have one AOD coordinator which restricts the capacity to ensure clients can be supported and access treatment on communities;
- SHSAC have one Aboriginal mental health worker to run their Tobacco Control and Other Substances Program and recognize the need to do more in this area and also to support those accessing town based services to return and live in their community;
- SUS have no specific staff to work with clients and no staffing capacity to assess, counsel or refer clients.

**Purpose of the study**

- To provide a background in the form of a working document, to the AOD related responses in the Katherine region and provide information on the current state of services and interventions;
- To conduct an environmental scan of the existing services and infrastructure which supports people and their families who are seeking treatment, rehabilitation, and support;
To raise community awareness of the Katherine Regional Aboriginal and Health Related Services (KRAHRS) Healing Pathways Project (HPP) which is attempting to highlight the significant gaps in service coordination and shortfalls in the capacity of existing services;

To provide a framework to facilitate service coordination and improve service delivery for clients with alcohol related issues;

To provide evidence to support funding applications by AOD related services;

**Conclusion**

This report concludes that significant gaps in service delivery and barriers to access exist in AOD related services in the Katherine region. There is a major issue concerning the capacity of services to provide an adequate level of care to clients. This is largely the result of the inability to recruit and retain appropriate staff and this is partially the result of underfunding.

There are also major barriers for people needing to access multiple types of services throughout treatment and rehabilitation and this is largely the result of poor communication between services and a poor understanding between services of their respective roles and this needs to be addressed.

What is required is the creation of structured pathways for people needing to access adequate service and treatment resources, with coordination at a community level rather than an individual level.

**Recommendations**

This document may be considered a base document highlighting service delivery shortfalls and gaps. The solutions to these issues are beyond the scope of this document and constitute the next phase of study. Nevertheless there are a number of suggestions and recommendations that can be made to guide this next phase.

There is a critical shortage of counsellors and personnel qualified in the areas of AOD and mental health (MH) disciplines identified by all services. It is recommended that services address this as matter of high priority. It may be necessary for services to collaborate to find a solution to this shortage, possibly through the medium of KRAHRS. Some thought should be given by services with extremely limited resources to exploring ways in which a counsellor may be shared, again KRAHRS may be able to auspice this initiative.

Ongoing and follow up care is essential in reducing the frequency of relapse (McLellan 2002). Unfortunately as Gray et al. (2010) notes there is a lack of such services for Indigenous Australians in the Katherine Region. This needs to be addressed in two ways, firstly by providing a home support service and secondly by developing vocational pathways and opportunities both for clients exiting treatment.
and as a divisionary preventative program. It is recommended that the above options be examined.

To address the shortfall in support to clients living in regional areas, it is recommended that a model to address this be developed. One workable option would be to have at least one health worker/project worker in each community with some basic training in mental health literacy and AOD counselling. These personnel should ideally be supported by a trained professional based in Katherine who has the ability to travel to remote communities as the need arises.

1.0 Background

In the Northern Territory (NT) there is an ongoing problem with the harmful use of alcohol. Menzies School of Health indicated in 2008 high rates of alcohol consumption by persons aged 15 and over in the Northern Territory was equivalent to 14.5 litres of absolute alcohol, nearly 50% above the national level of 9.95 litres of absolute alcohol (d’Abbs, 2010). The burden of alcohol-related harm in Indigenous communities is now widely appreciated and contributes significantly to premature mortality and excess morbidity across the lifespan (Hunter, Brown & McCulloch, 2003).

In terms of drinking patterns, Indigenous Australians are approximately twice as likely to consume alcohol at a level that increases their risk of harm in the long term, and approximately 1.5 times more likely to drink in a manner that increases their risk of harm in the short term (Australian Institute of Health and Welfare 2003). The harmful use of alcohol is recognised as a contributor to the excess of both physical and mental health disorders and comorbidity that, in the wider population, regardless of primacy, leads to poorer outcomes (Proudfoot et al 2003; Burke et al, 2007). Alcohol related social problems are also disproportionately high in Indigenous communities: 71.3% of Indigenous homicides between 1999 and 2003 occurred in situations where both perpetrator and victim were drinking compared with 19.5 of non-Indigenous homicides (SCRGSP 2005).

Katherine, located 312km south-east of Darwin along the Stuart Highway, has an estimated population of 8,193, a quarter of whom are Indigenous (d’Abbs, 2010). Historically the Katherine area has been home to the Jawoyn, Wardaman, Dagoman and Mialli people. The Municipality of Katherine covers an area of 7,421 square kilometers and is located on the Katherine River. The Katherine Region is 336,674 square kilometers (about the size of France) and incorporates the Katherine township and outlying populations from the townships of Pine Creek, Mataranka, Larrimah, Timber Creek, Daly Waters and Borroloola as well as Indigenous communities including Ngukurr, Barunga, Bulman, Lajamanu, Kybrook and Kalkarindji.

Over the recent decades policy responses to alcohol related issues in Katherine have focused on Aboriginal people. The NTER mandated that prescribed Aboriginal
communities be alcohol free, and this has resulted in people coming into Katherine to access the restricted but available alcohol supply. The impact on Katherine of the creation of dry communities has been considerable, with the effect of increasing demand and pressure on Katherine based treatment and support services. Related families have been impacted with respect to overcrowding, and this has led to an increase in the levels of arrests for public drunkenness, anti-social behavior and matters regarding community safety.

To provide an example, in December 2011 a profile report conducted by the Police on the community of Geyulken highlights the significant and ongoing alcohol issues affecting the Katherine region (pers.comm.). The community of Geyulken (aka Walkpri Camp) is located within walking distance from the main shopping center of Katherine. In the last 12 months the police involvement at the community had risen by 245%, with the majority of offending behaviour occurring during evening hours. Alcohol was also a major contributing factor in reports of domestic violence and general disturbances. People who were travelling from remote locations, such as Yuendumu and Lajamanu were found to be residing at Geyulken, while staying in Katherine, resulting in significant overcrowding.

Katherine’s collective alcohol related service sector, prior to the NTER in 2007, consisted of a handful of specific alcohol related services and programs. Over the past decade, these have grown to include a sobering up shelter, residential rehabilitation facility and the government run alcohol and other drug program. The NTER report (2008) explained how alcohol management service provider needs have increased as a result of the intervention. In response monies allocated for Katherine included two withdrawal beds at Katherine Hospital, 11 more beds at the residential rehabilitation centre and funding for more staff at both WWHS and KWHB.

Separate to the NTER findings further resources have been developed which include Strongbala Men’s Health Program, Wurli-Wurlinjang’s alcohol and other drugs program, Mission Australia’s (MA) Intervention Case Management Service and new Sobering Up Shelter (to replace their previous one) and a Transitional Aftercare Facility (Kalano – Venndale).

In recent years Alice Springs has received extensive investments in the form of new and refurbished housing, improved road and essential services infrastructure and social support services. More than $25 million has been committed to improve social support services including alcohol rehabilitation, tenancy support and family support services (FaCSHIA, 2011).

In comparison, it is of the opinion of many service providers, that Katherine has been severely underfunded for the provision of AOD services when compared to the funding governments have provided to Alice Springs. For example, in 2007 Kalano Community Association Inc. were given 8 demountables by the Australian Government for use as short term accommodation. However the units have never been commissioned as funds were not provided for operation or maintenance.
(d’Abbs 2010). Arguably the alcohol related issues in Katherine are as bad if not worse than Alice Springs, although Katherine has not received the high media profile that has occurred in Alice Springs. For example Katherine police stated that in 2010 there were 7,433 protective custody arrests in Katherine compared to 7,378 in Alice Springs (pers. comm). These figures do not include protective custody’s taken to the Sobering up Shelter or to their home. Considering that the population of Alice Springs is over 2½ times larger than Katherine it is not difficult to imagine the problems Aboriginal families and communities are trying to deal with in Katherine with little opportunity for support.

This report aims to document the gaps in service coordination and the shortfalls that exist in both service capacity and delivery in the Katherine region. The successor to the NTER policy that finishes in 2012 is the Stronger Futures Policy which in partnership with the Northern Territory Government (NTG) is working with Aboriginal people in the NT to build stronger futures together. Tackling the harmful use of alcohol is one of the key proposed areas for future action, the others include increasing school attendance for children, providing decent housing, building strong local economies and increasing job opportunities. There has been no information released to date which details how this money will be spent or allocated.

2.0 Response

As d’Abbs and Gray et all (1999) have noted, alcohol problems were well on the agenda in Katherine prior to 1999. Below is a list of the groups and committees created to tackle the harmful use of alcohol in Katherine. Only three of those have included representation by Aboriginal organisations, and these are marked by an asterisk.

1996 Katherine Anti-Social Behaviour Committee (KASBSC)
1998 Alcohol Related Anti-Social Behavioral Sub-Committee (ARASBSC)
2003 Katherine Regional Harmony Group (KRHG)*
2007 Interagency Tasking and Coordination Group (ITCG)
2007 Katherine Alcohol Services Meeting (KASM)
2008 Alcohol Reference Group (ARG)
2010 Katherine Regional Action Group (KRAMG) *
2011 Katherine Indigenous Alcohol Reference Group (KIARG) *

The alcohol related issues in Katherine were framed around the concept of anti-social behavior by the KASBSC. A description of this term and its connotations is given by d’Abbs et al, (1999) who state:

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1 Although Aboriginal organisations were invited to the ITCG group they declined to be involved because it was perceived as a government driven top-down process with little room for community involvement. As a result several Aboriginal organisations believed this process would exclude them from meaningful participation in designing and implementing the alcohol management plan. For a fuller explanation of this see (d’Abbs et al, 2010, p12)).
In Katherine, the term ‘anti-social behaviour’ most frequently refers to public drunkenness and behaviour associated with public drunkenness. However, there is a lack of consensus in the town about the range of behaviours the term encompasses. ‘Anti-social behaviour’ appears to refer to any behaviour that is regarded as deviant by members of the dominant society, and the majority of people in Katherine take it for granted that it refers to the actions of Aboriginal drinkers. Several interviewees pointed out that it is often simply a code phrase for ‘being black and being in public’, therefore providing non-Aboriginals a mechanism for talking about Aboriginal drinking without using language that might be criticised as racist (p62).

This framing of the problem in terms of the “anti-social behavior” of a small number of individuals:

...however appealing it may be to some because of its simplicity, is not an adequate description or definition of those problems, and hence does not constitute an adequate basis on which to build solutions (ibid. p16).

In the same report the authors note the lack of involvement of any Aboriginal Organisations in finding solutions to the alcohol related problems in Katherine, particularly in view of the fact that the “anti-social behavior” as framed by the ARASBSC was seen as an Aboriginal phenomena, and further noting:

If there is one lesson that we believe emerges quite clearly from the historical record it is this: attempts to control Aboriginal use of recreational drugs that do not involve full participation by relevant Aboriginal organisations are doomed to fail. This does not mean that attempts that do involve Aboriginal organisations are destined to succeed. But, unlike attempts foisted on Aboriginal people by white people, they have a chance of success (ibid p17).

The Katherine Region Harmony Group (KRHG) formed in 2007 outlined supply, demand and harm reduction strategies for a Katherine specific alcohol management plan (Katherine Region Harmony Group, 2007). A plan was developed which subsequently became the Katherine Alcohol Management Plan (KAMP), and was endorsed by the NT Licensing commission in 2007. A variety of groups, including the Alcohol Reference Group (ARG); the Interagency Tasking and Coordination Group (ITCG) and KRHG have taken the lead with alcohol related measures since then and have done so with little Aboriginal participation.

As a result of the NTER in 2007, and a continued perception that Aboriginal organisations were being excluded from any participation of initiatives involving Aboriginal people, the KAMP was evaluated by the Menzies School of Research in 2010. The investigators surveyed local people asking whether they thought that the problems related to alcohol misuse in Katherine had changed in the last 12 months. A majority (58%) of those interviewed reported things had not changed, while 26% reported they thought that the situation had in fact got worse. It was clear from
responses that alcohol-related problems in Katherine were widely seen as being synonymous with Indigenous public drunkenness in the town. The evaluation recommended amongst other things that all measures be reviewed and that the KAMP should be further developed, involving Indigenous agencies, to become a genuine plan with adequate administrative support. Furthermore, recommendations placed emphasis on acute and chronic harms arising from alcohol misuse and that any group taking the lead on this should identify and secure resources for demand and harm reduction measures (d’Abbs et al. 2010).

In the KAMP (2007) measures were grouped under the three headings of Supply Reduction, Harm Reduction and Demand Reduction. Under the Demand reduction measures the establishment of a “Healing Pathway” was proposed to link early intervention services with access to withdrawal management, rehabilitation and post-discharge programs. The “Healing Pathway” would link all essential services that would be required by a client to successfully recover from the harmful use of alcohol. This would range from treatment and rehabilitative services to those that would work with the whole family to provide support. The support would involve engaging with the wider social issues impacting on the person and providing direction and employment opportunities. This would be achieved through the coordination of services to provide continuity of care for the client, supported through effective case-management practices and directed by referral pathways.

The Healing Pathways became the Katherine Regional Aboriginal Health and Related Services (KRAHRS) Healing Pathways Project (HPP) in 2008. Similarly, as mentioned in the KAMP, the KRAHRS HPP’s objectives were to identify treatment/referral pathways and to coordinate services to ensure continuity of care for clients, particularly case-management services. The other main objective of the project was to identify the gaps in alcohol related service provision and seek to address these, through a collective and coordinated response from stakeholders and Aboriginal Community Controlled Organisations.

The HPP was seen by KRAHRS, its member Aboriginal Community Controlled Organisations and key stakeholders to be a bottom-up approach, which would identify from local knowledge the service shortfalls and gaps in coordination of those services that must be addressed in order to provide optimal support for the client.

A number of recent alcohol NT reforms2 (during 2011) were introduced and again the Katherine Aboriginal Community Controlled Organisations have not participated in any of their development. It is a collective view by such organisations these reforms maintain a punitive approach to dealing with issues relating to the harmful

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2 These include; 1. Banning problem drinkers from purchasing takeaway alcohol. 2. Introducing mandatory rehabilitation treatment for problem drinkers. 3. Rolling out a new Territory-wide Banned Drinker Register in all take away liquor outlets. 4. Replacing the existing Alcohol Court with a Substance Misuse Assessment and Referral for Treatment (SMART) Court. 5. Expanding and enhancing rehabilitation and treatment options for problem drinker.
use of alcohol and anti-social behaviour but have not provided any legislative or appropriate budgetary resourcing to ensure such issues can be addressed in a broader approach.

In response to problems concerning the consultation process of Aboriginal people with regard to government policy development, legislation and reforms, the Katherine Indigenous Alcohol Reference Group (KIARG) was created by Wurli-Wurlinjang to be the voice that could speak on behalf of the Indigenous people of Katherine with cultural authority about alcohol related matters affecting their people and communities.

The Katherine Region Action Group (KRAG) was formed in early 2011 to review the 2007 KAMP after it was evaluated by the Menzies School of Health Research. The evaluation focused on the importance of the Katherine community being centrally involved in constructing and over-sighti
ng a new Alcohol Management Plan. The group includes all but one of the Aboriginal Community Controlled Organisations and in April 2011, the KRAHRS HPP briefed KRAG on the projects progress and the gaps that had been identified so far with regard to the capacity of existing services and the absence of some essential services, both in Katherine and regionally.

The Healing Pathways Project initiatives are in line with the National Drug Strategy and are continuing to be recognised as key component to the revised Katherine Alcohol Management Plan 2012-2014 yet to be released. Ultimately the project seeks to facilitate the coordination of services and establish the necessary linkages for clients needing service provision at the differing stages of their treatment. Throughout the projects' consultations with stakeholders it has become clear that, in the current environment, major barriers exist to securing effective outcomes for clients and to address this a broader approach is necessary.

### 3.0 Purpose of the study

The purpose of this study is to:

- To provide a background in the form of a working document, to the AOD related responses in the Katherine region and provide information on the current state of services and interventions;

- To conduct an environmental scan of the existing services and infrastructure which supports people and their families who are seeking treatment, rehabilitation, and support;

- To raise community awareness of the KRAHRS Healing Pathways Project which is attempting to highlight the significant gaps in service coordination and shortfalls in the capacity of existing services;
- To provide a framework to facilitate service coordination and improve service delivery for clients with alcohol related issues;

- To provide evidence to support funding applications by AOD related services;

### 4.0 Method

The KRAHRS Healing Pathways Project Coordinator initially contacted the Centre for Remote Health (CRH) Katherine Unit, research team during March 2011 to discuss the best methods of conducting a needs/gaps analysis of alcohol and related services in the Katherine region.

Several meetings between KRAHRS and CRH followed which provided direction for the project coordinator and a collaborative approach to ensure the desired goals and outcomes could be achieved. A participant action research (PAR) approach was taken where CRH personnel acted as facilitators providing advice on data collection, and documentation, and with the Healing Pathways Project Coordinator actively interacting with stakeholders with the objective of involving the stakeholders in addition to collecting and documenting data. Data was collected from all services in Katherine providing services related to the harmful use of alcohol. This was done by standardized questionnaires and followed up by semi-structured interviews. During this process stakeholders were encouraged to discuss strengths and weaknesses of their service and how they might think service delivery overall could be improved.

The data collected by the project coordinator was reviewed with CRH in meetings that were arranged every 2-4 weeks. On completion of the data analysis a draft report was completed, with the assistance of the CRH research team, and forwarded to stakeholders for feedback. The final report was then sent to the CRH research team to prepare it into an academically acceptable document. See Appendix 1 for a list of services interviewed.

### 5.0 Current Environment

Katherine has approximately fifty social services which are run by a variety of Aboriginal, non-Aboriginal, government and non-government organizations. Of these, seven services are specifically funded for alcohol initiatives and are run by five organizations. These are:

1. Venndale Rehabilitation - Kalano/Venndale
2. Venndale Transitional After Care - Kalano/Venndale
3. Alcohol and other Drugs Program – Wurli Wurlinjang Health Service
4. Sobering Up Shelter/Yarralah - Mission Australia
5. Alcohol and Other Drugs Program - Department of Health
6. Katherine Hospital – Department of Health
7. Alcohol Tobacco and Other Drugs Program - Katherine Health West Board
Other services that have a mandate to work with clients with alcohol related issues and are relevant to this study include crises accommodation services, complimentary services, legal and correctional services.

These are:
- Intervention Case Management Service - Mission Australia
- Strongbala Healthy Men’s 4 Life Program - WWHS
- Women’s Crisis Centre
- Ormond House - Men’s Crisis Accommodation
- Northern Australian Aboriginal Justice Agency (NAAJA)
- Northern Territory Community Correctional Services (NTCCS)

Regionally programs include:
- The Department of Health Alcohol and Other Drugs Program
- In the Katherine West region, Katherine West Health Board runs their AOD regional program
- In the East Sunrise Health Service Aboriginal Corporation’s Tobacco Control and Other Substances Program.

The tables below list the town based communities and their distance from Katherine town. The tables also highlight which health organisation, and government provides services to them:

<table>
<thead>
<tr>
<th>Town Based Communities</th>
<th>Km’s from Katherine</th>
<th>WWHS</th>
<th>Kalano</th>
<th>NT Gov</th>
</tr>
</thead>
<tbody>
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<td>Binjari</td>
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<td>*</td>
<td>*</td>
<td>*</td>
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<td>Miali Brumbry</td>
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<td>*</td>
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<td>Jodeluk</td>
<td>22</td>
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</tbody>
</table>

In Katherine there is a perception among stakeholders that a repeating cycle exists where people are being apprehended by police or picked up by the community patrol because of public intoxication, taken to a service to sober up and then released without further intervention, follow up or support.

Katherine based services believe these people to be either “long-grassing” and/or homeless and may have come in from their community. People will get together with others who are drinking, share the financial costs and find a place to sit and drink. Later in the night some of these people are picked up by various services including Community Patrol, Police or St John Ambulance and are taken to Yarralah.

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3 Long-grassing is a local term used by stakeholders to describe the choice of an individual who chooses to sleep and lodge in outside places rather than set accommodation, for example a location in Katherine is the river bank.
(SUS), Police Custody, their own home or the hospital as a result of their intoxication levels and/or associated behavior.

Feedback from services indicate a handful of people are regularly presenting to services and it is obvious this lifestyle is impacting on their health and well-being and their families.

The SUS is considered to be full Friday through to Saturday and police custody cells can hold a legal maximum of 90 people. It is not uncommon for both places to be operating near or at capacity over a weekend.

6.0 Infrastructure

The following infrastructure relating to AOD service provision was identified and includes:

Katherine

1. Venndale Residential Rehabilitation Centre
2. Venndale Transitional After Care
3. Yarralah Sobering Up Shelter
4. Katherine Hospital
5. Wurli Wurlinjang Health Service – (clinic and social and emotional unit)
6. Strongbala Men’s Health Facility
7. Ormond House men’s accommodation
8. Women’s Crisis Centre

Regionally

Infrastructure in the regional areas is limited and consists of the health clinics run by the respective Aboriginal Health Services. As far as the authors are aware there are no other structures to provide spaces for counselling and treatment options.

7.0 Services and programs

This section details each service in terms of infrastructure (facility) and the programs run, followed by capacity issues and shortfalls.

The information aims to provide an overview of the program delivery and capacity, waiting times, access to service, staff and staffing issues, and other gaps that are identified as barriers to effective client outcomes.
7.1 Katherine

7.1.1 Venndale Rehabilitation Centre (Kalano)

Residential facility located on Bruce Road approximately 33km out of town. It is located 3 kilometers past the Cutta Cutta Caves turn off, south of Katherine on the Stuart Highway. At Venndale there is a large administration area where all groups are conducted, a large client recreation room and a large kitchen and dining area where the on-site cook prepares all meals. Venndale currently occupies 4 of 16 acres of Jawoyn Land.

Venndale is currently funded for 24 beds, which is to increase to 28 beds by April 2012 and then to 36 before the end of 2013. Twenty of these beds are currently funded by the Office for Aboriginal and Torres Strait Islander Health and the remainder are being funded by the Department of Justice.

Limitations

Venndale reported they can justify the need for 50-60 beds in order to meet Katherine and regional Katherine’s current needs. The facility cannot support families and as a result WWHS report they are referring 1-2 families per week to Darwin where a family-inclusive service can be accessed. There are other families that are not accepting referrals as a result of the associated travel requirements.

There are concerns around the impact of the new alcohol reforms, which will most likely increase the number of people needing to access rehabilitation. These numbers are estimated to initially be small but then increase as processes around SMART court and tribunal outcomes become evident. The initial estimate of 40 beds and 20 for families will also need to increase given the impact of the reforms. The Manager reports that funding/beds provided for this through New Era will not meet the demand as indicated by current statistics as of January 2012 but it will help. However, until a clinician is based in Katherine on a full time basis to assess these clients they are not going to see them and they will just continue on the cycle of harm/locked up that they are currently engaged in.

The Program

Venndale run a structured holistic abstinence AOD program for clients, whilst having a primary focus on clients attending relapse prevention education groups. Other components of a holistic program include AOD counselling sessions, literacy and numeracy, self-esteem, fitness groups, healthy lifestyles and a volunteer worker’s program. Health, business components and outings such as sporting and fishing also take place.

Venndale is currently one of the only rehabilitation centers in the NT who consider and accept clients with mental health issues and currently has a relationship where
assistance is provided from the NTG Health’s Mental Health division. It also identifies a need for Venndale to have a Social & Emotional Counsellor on hand as in the past attempts have been made through HPP initiatives with WWHS and the NTG’s AOD program to provide counseling. However evaluations have found that Venndale ideally needs its own counsellor on site to meet clients needs.

Venndale rehabilitation facility cannot accommodate people under 18 years old. Therefore families and youth in the region are required to travel to Darwin for this service.

Venndale offers clients 3 months of rehabilitation with the opportunity for up to 6 months if required, however if a client is not ready to leave then a client will never be forcefully discharged. As mentioned by the Venndale manager:

We have had a client here for a period of 9 months before stating the fear of relapse as their reason for staying. We have found during the processes of Relapse Prevention groups that a lot of Venndale clients indicate that avoiding family influence to drink will be a problem and therefore require more time to build the avoidance skills required.

As of 2011 the average stay for a client was approximately 56 days (capacity of 24 clients), and this has increased from 13 days in 2008 (capacity of 11 clients). There are now more clients accessing rehabilitation services for longer periods of time. This must be attributed to the increased program schedule that provides approximately 10 hours of interaction per day along with the remote, quiet location. Historically the most common feedback was that clients were “bored” and an intensive program schedule has apparently remedied that.

Access to the Service

Services such as WWHS, Mission Australia and the Department of Health report they can collectively refer up to 20 clients to Venndale per week. However because Venndale is always at capacity often these services will not refer and statistics of referrals that cannot be accepted are not representative of the situation. The SUS also reported that many of the clinics will not refer to Venndale because they are aware of the waiting periods, when often their clients need to access a service immediately.

Venndale acknowledges that it may take more time and resources but feels that all of the clients that are presently not gaining access, for the above reasons, should be assessed anyway, to allow them equal access to the service. In the very near future Venndale will have a Community Patrol and Outreach Service available that can monitor such clients until a time comes when Venndale can offer them a more appropriate service.
As the manager stated:

These people may fall through the cracks if we don’t attempt to help them, ‘ear tagging’ for lack of better words is the key to maintaining contact with these clients perhaps this could be done through the Healing Pathways website to indicate that this person indicated an interest in rehab, if they are partly assessed already it will short cut and speed up the admissions process.

He also noted that “these people may also be able to attend VTAC, but if they are not assessed we will never know”.

As previously mentioned Venndale Rehabilitation does not accommodate families.

Clients who abscond or are removed, mainly for being found with alcohol and other drugs in their possession, from Venndale or VTAC must wait 6 weeks before being re-admitted. This policy can be discussed between program management and the referrer and is assessed on a case by case basis. The client can be re-assessed as soon as they leave but must wait the required time period, 6 weeks, before being re-admitted.

This policy is currently under review and is being facilitated by the Kalano Chief Executive Officer, Senior Cultural Advisor and Board of Management. Venndale have reported the need to re-assess due to the interruption it causes to a person’s need for treatment. Venndale have asked specifically for advice in order to prepare a new policy for this based on the following issues:

1. People who need to leave for personal reasons
2. People who need to leave for cultural reasons
3. Absconding
4. Involuntary discharge
5. Funeral Leave Policy

Program Capacity

Case-Management and Program Delivery

Venndale has funding for 4 case-managers (6 clients per case-manager; 8 has been defined as the maximum by the Department of Health’s (DoH) requirements). These positions are required to have a minimum qualification of Certificate 2 in AOD which is a DoH standard. Venndale has historically found it very hard to attract qualified, Indigenous staff, specifically to fill the roles of Case Manager. Kalano see the need for assistance at a community level to implement a Registered Training Organization status where they have the ability to train Aboriginal people from the communities surrounding Katherine with a view to Venndale being operated solely by Aboriginal staff.
The case-managers at Venndale, in addition to providing case-management, also provide AOD counselling even though they are not qualified in this area. Venndale currently support an external service (NTG-AOD) to provide these counselling needs but this has been hard to schedule as most needs for counselling are spontaneous, hence the need for a dedicated social and emotional wellbeing counsellor. Other duties include program delivery, logistics and transport and all administration matters for their clients. It was reported that case-managers feel they are unable to deliver the appropriate level of case-management their clients deserve due to the lack of staffing resources. Case-managers are considered integral to effective client outcomes, however this is severely compromised due to time being taken up by other duties.

Counselling
- Co morbidities of AOD and mental health issues have been consistently identified through admissions assessments. Although Venndale recognizes the importance of addressing mental health issues, as part of the process of rehabilitation through case-management, it is not in a position to provide this service;
- Case-managers at Venndale are providing AOD counselling, motivational interviewing and brief interventions, among other duties;
- For other counselling needs Venndale has utilised other services such as Mental Health, AOD and WWHS;
- Currently there are no qualified counsellors or mental health practitioners on-site that can provide treatment in key areas such as anger management, grief and loss, life coaching, couples and marriage counselling, cultural and spiritual, anxiety and depression along with any other mental health related needs;

Waiting Periods

Venndale Rehabilitation reports all beds are accounted for 100% of the time. This figure is reported to be fairly accurate over the last few years. Waiting periods have been on average a minimum of 4-6 months. Venndale is turning away a reported 10-15 potential clients on average per month, of which an estimated 3-4 have previously accessed the program. However an attempt is made to find a solution for every client, and this includes admission to VTAC and participation in a day program externally; admission to Venndale before a bed is available or attachment to an external service. As a result this has had an impact on the wider community services that have become less inclined to consider Venndale as a referral option due to the long waiting period situation. The actual figures of clients that could be potentially referred to Venndale for one month are presumed to be even greater.
Current Staff

Currently there are 11 staff members but funding exists for 16. The staff positions are listed below:

- One Program Manager (Diploma - Higher)
- One Clinical Manager (Diploma or higher)
- Four Case Managers (Cert 2 or 4)
- One Admissions Coordinator (Cert 2 – 4)
- Three Outreach Workers (Cert 2 – 4)
- One Care Taker/Cook (Cert 2 – 4)
- Three Support workers (Cert 2 – 4)
- Three Casual Staff

Venndale requires all staff, excluding casual staff to participate in the NTG AOD Cert 2–4 program, and all of the staff must maintain a current First Aid Certificate and be cleared with a criminal history check. Case-managers are trained to provide AOD specific counselling but are not qualified counsellors. They also provide, Brief Interventions (BI) and Motivational Interviewing (MI). MI is the most appropriate form of counselling used and brief interventions are only used when clients are attempting to leave the program early. On average 4-5 clients per month want to exit the program early.

Staffing Issues

As with many other services in Katherine there are serious issues concerning recruiting and retaining staff. The inability to attract and retain qualified and experienced staff has been found to relate to the limited incentives Venndale are able to offer. Venndale have formally approached the Federal Government’s Department of Health & Aging (DH&A) for assistance with this issue. The program manager reported that in a recent study he did it was discovered that all positions at Venndale were underpaid by between $5,000 - $15,000 per annum. The manager stated that he “would love to be in a position to pay staff what they deserve but they were simply not funded enough to do so”.

Identified Staffing needs:

- General Practitioner (GP) - services are accessed at WWHS. Waiting times on top of traveling and logistic related issues challenge Venndale’s resources to efficiently access GP services which are seen as key to the health of their clients. It was stated that clients generally wait between 4–7 hours to see a primary health care practitioner and due to a lack of appropriate personnel the Case Manager accompanies them and acts as a support worker which causes them to be away from Venndale. Venndale see the need for a full time or shared doctor with one of the Aboriginal Medical Services (AMS) that can be accessed on
demand by Venndale but be utilised by that AMS as an additional doctor. Venndale would need a support worker who can assist this process with logistics.

- Mental Health – as previously discussed comorbidities relating to alcohol and mental health have been recognized. There is a need for staff trained in mental health literacy who could deliver appropriate mental health programs including counselling. Initiatives between HPP and Venndale have highlighted the need for a social and emotional wellbeing counsellor who would be on site. This is seen as important given that unlike many rehabilitation services in the NT they do accept clients with mental health issues. Despite Venndale seeing this as crucial to clients’ needs it was noted that past requests to have this need resourced has been denied.

- More capacity for staff to deliver education to clients.

- Aboriginal Staff – Kalano Community Association is an Aboriginal based organisation and recognises the need to have Indigenous employees. However funding requirements state that prospective staff must be qualified or experienced which makes it extremely difficult to hire Indigenous staff.

- Administration staff – there is currently no administrative staff for the facility. Administration tasks are being carried out by case-managers, the program manager and the clinical manager. The need for a separate administration person to assist with general enquiries, rostering, staff appointments, finances etc. has been identified at Venndale to increase the productivity and client to case-management time.

- Transport and logistics – staff are frequently taking clients to appointments and other places in town, which leaves the facility short of staff who are then required to take on the task of the missing staff member plus their own. A full time person is needed to take clients into town to make appointments, attend classes, manage finances, shopping etc to allow the case-managers to do their own work.

**Other Identified Limitations**

Being able to cater for the family. There is no facility in Katherine where the family as a whole can participate in the program. The nearest facility for families to access services is the Council for Aboriginal Alcohol Program Services (CAAPS) in Darwin.

The program cannot accept youth. Again younger people can only access these services in Darwin or elsewhere. There is a growing need for this to be available particularly in youth AOD, binge drinking and volatile substance related issues. Venndale has the support from NTG to fund a facility if the capital can be secured to build a volatile substance facility mixed with a facility for youth with AOD issues and homelessness issues. Venndale currently has a submission with the Aboriginal
Benefits Account. They are still awaiting a response and have been advised that it currently sits with the local division of the Indigenous Coordination Centre.

Allowing people who have been evicted to re-enter the program or ensuring these people are linked to another service.

### 7.1.2 Venndale Transitional After Care facility (Kalano)

Venndale Transitional After Care facility, opened in October/November 2010 and is funded to provide transitional after care services for clients who are exiting Venndale or another AOD treatment program and are moving towards independent living. This is a 24 hour a day facility with the gates being locked from 6pm - 8am. During this period clients still may leave and enter the facility depending on individual mandated requirements/orders. The facility is funded to provide ten beds and the cost is $85 per week for accommodation, plus the cost of power and food must be covered by the client.

The occupancy rate ranges between 20% and 50% and the manager noted that this low rate was mainly due to the fact that clients leaving the Venndale Rehabilitation facility felt that they did not require after care services and therefore did not go. The aftercare program is currently non-compulsory and it has been found that clients in the Venndale Program don’t see the value in attending this program. Venndale Rehabilitation Services are addressing this issue by delivering group sessions focused on the theory of aftercare and in addition are involved in discussions to make after care a part of treatment for the legally referred clients.

**The Program**

The structure of the program is designed to upskill clients and prepare them for independent living and entering the workforce. Components of the program delivered include linking with job capacity services, community development projects, life skills, relapse prevention, work force life-skills training and employment and education assistance. It is compulsory for every participant in the aftercare program to participate in some sort of day program, for example some clients are involved in training and employment, others attend day programs provided by Venndale or participate in the Strongbala Program, provided by WWHS.

The program has the capacity to support clients leaving Venndale Rehabilitation Facility and who are intending to move back into independent living. This is done by providing residential support and assisting clients to link with other services including the Community Development Education Program (CDEP) at Kalano. However the program was reported to be limited by what they can be offered to clients with respect to training and employment opportunities. Average length of stay has been difficult to determine given the facility has been operational for such a short time and has catered for smaller numbers than expected.
Access to Service

Clients can access this service both pre and post attendance at the Venndale Rehabilitation Centre and from any other AOD treatment program. Clients need to have a medical check and power card to enter the service. As VTAC is being used as a holding facility for clients wanting to enter the rehabilitation service when it is full clients can come from any service in this instance.

The current caretaker stated that some of VTAC clients were asked to leave because they were found to be in possession or under the influence of illicit substances and this is strictly against Venndale policy. In such a case the client must leave the facility and cannot return in under six weeks and this applies to both VTAC and the Venndale Rehabilitation Center.

If the client is intoxicated there may be no ability to talk or prepare handover/referral plans with the client which reduces access. However in all other cases a positive outcome is always sought for clients including sourcing a safe environment for an involuntary discharged client. There is a concern that these clients are without care and support and it is seen by the service as crucial that these clients are linked back into a rehabilitation or other supporting service. This is deemed necessary in order to maintain the support these clients need and links with Outreach and Community Patrol to assist in this process are being explored.

Some clients have resisted being referred to this service for a number of reasons that include cost and the reduced level of independence a client has whilst at the service. Because of low occupancy rates at present there is no waiting period.

Program Capacity

The facility has one supervisor and this person must remain on site 24 hours a day. This was thought to place severe limitations on the capacity to further develop the program. For example an evening based life-skills program has been identified as a useful addition to the program in order to foster a culture of what the manager termed “nine to five” living. The manager stated that the program would cover:

- Basic theories such as what to do when you get home from work, getting to bed early, washing, showering, making sure your children are fed and put to bed early, making lunch for the following day, getting up early, getting your kids to school and getting to work on time.

However due to present resource levels this cannot be implemented.

Current Staff

- One day-support worker
- One afternoon-support worker
Identified Staffing needs

Given there is one staff on at a time this role is limited to do any case-management as required. Therefore case-management has been identified as a need to assist clients to ensure that post-transitional care needs are identified and support structures are established with other services.

A life skills coordinator for an evening program has been identified as an opportune time to engage clients at the facility.

Administration support – Venndale has highlighted the need for administration support during the day to assist the Support Worker.

VTAC have identified the need to have staff that would focus on ensuring clients are accessing appropriate services whether this be rehabilitation and treatment (stage 1) or education and employment services (stage 2). These workers would also provide the extra resources and support necessary to carry out programs and case-manage client needs. Staff members would ideally be Indigenous and/or have acquired relevant training.

Other Identified Gaps

Home support is recognised as a need for clients who succeeded in the program and want to return home to a supportive environment which includes being supported by family. Currently when clients return home it is to an environment where family members are drinking and this adversely influences the client into recidivism. There is an identified need for either the program or an alternative program to work with the family or home environment to ensure clients can manage their issues. This issue will be addressed by the soon to be active Venndale Outreach Service which will provide support post the aftercare program. All outreach staff are to be enrolled and studying the Alcohol and Other Drugs Certificate 2 - 4. They will also be upskilled in Brief Intervention and Motivational Interviewing techniques. This initiative will add an element that was previously unavailable in Katherine.

Currently the Vocational Training and Education Centre (VTEC) in Katherine does not have the capacity to enable their clients to access existing services due to staffing restrictions and the capacity of the program. There are concerns that an opportunity to provide training and education in order to link it to local industries is being missed particularly in the light of recent increased mining activities in the Katherine region. There is a perceived need for a centre linked into community corrections and local/regional industry that could provide TAFE courses in areas that reflect the trade needs of the region.
7.1.3 **Wurli Wurlinjang Health Service (clinic and social and emotional wellbeing unit)**

The main clinic comprises of ten consulting rooms and fully equipped treatment rooms which can be utilised for emergency care and wound dressing. A second clinic is located on Kintore Street and is the Gudbinji chronic disease management centre which provides chronic disease self management programs and provides primary health care to about one third of Wurli-Wurlinjang clients. There are also several other locations where doctors consult including the Strongbala site which is located approximately three kilometers out of town on the McKeddie road.

Wurli Wurlinjang is an Australian General Practice Accreditation Limited (AGPAL) accredited Aboriginal community controlled primary health care provider and comprises of three sites. The main clinic is located on Third Street in Katherine and comprises of ten consulting rooms including a main clinic which deals with both acute care and chronic disease care. This service is provided for clients on both a recall and “walk-in” system.

The main clinic space is also utilized by the Women’s and Children’s program and occupies between 2 and 4 of the consulting rooms depending on the day. The program encompasses the ear program and also deals with acute presentations and planned management of clients using a recall system.

The Gudbinji chronic disease centre provides care for clients with chronic disease conditions and is located on Kintore Street. Here clients have regular clinical assessments, treatment and recalled follow-up of their ongoing conditions. Within Gudbinji are health promotion programs including Diabetes Day (Thursdays) and Heart Day (Fridays). These programs provide a holistic service which includes training in self-management, education sessions and healthy food preparation. Strongbala is the men’s health facility located on McKeddie road approximately three kilometres out of town. It is staffed regularly by a Registered Nurse Clinic Coordinator and two Aboriginal Health Workers and a receptionist. A doctor attends the facility each Thursday. Strongbala provides a holistic health care service that includes AOD assessments and treatment offered through the Wurli AOD program.

**Access to Service**

Wurli Wurlinjang provides transport service for clients to and from all its facilities and operates within a 30 kilometer radius of Katherine. Clients requiring transport can contact the clinic for pick up, while those that are due for a health check will be contacted and followed up.

People can also access the clinic on a walk-in basis or by the very limited appointment system. Usually, clients are seen as they register with reception, although there is facility to “fast-track” clients as appropriate.
Current Staffing

Current staffing levels stand at 95 and are broken down as follows:
- Five full-time and three part-time GPs
- Five Registered Nurses (three of which are clinically active)
- Fifteen registered Aboriginal health workers
- One dietician/health promotion officer with other allied health professionals accessed through KRAHRS
- Sixty six support workers

Identified staffing needs

Clinical services at Wurli are already operating at capacity. Clinicians deal with more than 23,000 client encounters annually and service a regular client list of about 4000. Many Indigenous visitors to Katherine also access Wurli-Wurlinjang’s services while they are in town.

7.1.3.1 The Clinic

The clinic provides access to many of the Indigenous people in and around Katherine, and clinical staff take advantage of this situation by conducting thorough health checks on clients and providing health education to all who visit the clinic. This provides the opportunity to identify health issues unrelated to the initial presentation. These can then be treated, and referred to specialist program areas as appropriate for follow up and management.

Many of the clients presenting have alcohol-related health issues and these clients undergo a formal alcohol and other drugs assessment as part of their consultation. Appropriate interventions are offered which include the AOD program or referral to Strongbala or Venndale Rehabilitation Centre.

Regular clients are followed up to assess progress in their physical conditions and in their progress with interactions with AOD services. They are offered periodic health checks in which risk factors for health are assessed and monitored. These include tobacco smoking and the use of alcohol and any illicit drugs. Every year, clients are assessed formally using the Alcohol Use Disorder Identification Test (AUDIT), a screening tool developed by the World Health Organisation to detect early signs of hazardous and harmful drinking patterns in individuals. Problem drinking is identified and responded to with brief interventions, referral to rehabilitation services or referral to the Wurli Wurlinjang AOD ambulatory program.

Program Capacity with respect to AOD

Currently doctors use the AUDIT screening tool during health checks and refer clients to their AOD program that is located within the Well Being Unit. This unit employs six staff, three of which provide social and emotional wellbeing counselling
and includes a part time psychologist and three working on the AOD program. This latter program consists of a coordinator and two indigenous alcohol workers. The section on Services gives a detailed description of this program.

**Identified Gaps**

Clients mandated for alcohol treatment following assessment and appearance at the alcohol tribunal cannot easily access the service because of their already stretched clinical services.

Clients referred for medical assessment will be unable to gain timely access to a qualified clinician to conduct such an assessment because of the lack of clinicians already.

Services that require a GP assessment by Wurli-Wurlinjang staff before being accepted to a service, for example clients from Venndale Transitional Care, have to endure long waiting periods which places stress on current resources of all health services involved. Often during the long waiting periods people abscond and therefore cannot access the VRC or VTAC for another six weeks leaving those people who have absconded and who are in need of support without supervision. Also the client who absconds has missed a health check that may highlight un-assessed or previously ignored health issues.

Other large community controlled Aboriginal Health Services in the NT for example Central Australian Aboriginal Congress (CAAC) in Alice Springs, Anyinginyi in Tennant Creek and Danila Dilba in Darwin have all introduced appointment systems to limit the number of clients accessing their services and so reduce the burden of excessive presentations and to offer relief to their staff. The result however is to deflect acute care clients to the local hospital a situation that is untenable in Katherine.

**7.1.3.2 Social and Emotional and Well Being Unit (Alcohol & Other Drugs (AOD) program)**

The Alcohol and Other Drugs program is located in the WWHS Well Being unit on Third Street in a house internally fitted out with office space including up to 3 counselling/consultation rooms, program areas, administration and has outdoor recreational area including washing and cleaning facilities, a garden area consultation/counselling room and office space.

The facility has the capacity to run various programs for individuals, groups both inside and outside with the outside facilities including a cooking area and bathrooms and showers. There is a medium to large size garden for recreational and agricultural use.
The Program

- Brief Interventions (BI’s) – initially offered to all clients of the service by non-specialist staff. Clients are offered BI’s at the first point of contact as a strategy for reducing the harms associated with high risk drinking;

- Brief Assessments – these are undertaken with all clients who have taken up the offer of Brief Interventions. Brief Assessments are utilised to identify the client’s alcohol consumption, risks relating to consumption levels, any mental health issues, the strengths of the client, and the support networks the client has or that can be put in place to support them to reduce their intake levels;

- Comprehensive Assessments – these are undertaken with all clients who are case managed by the program. Comprehensive Assessments identify such issues as frequency and levels of alcohol use;

- Support Services – where appropriate clients of the program are offered varying levels and types of support. This may include support during court matters, referral for other services such as financial counselling, housing, legal matters, child protection etc. The list of support services are varied and are tailored to the needs of the client;

- Counselling – this service is offered to all clients who either self-refer or who are referred by other Wurli programs or other external agencies. All counselling provided is based on Cognitive Behavioural Therapy (CBT);

- Therapy – this service is offered to clients who have undergone a Comprehensive Assessment which has been determined in conjunction with the client, and they feel that they would benefit from a structured therapeutic approach to address issues relating to alcohol and substance use which are significantly impacting on the their emotional and psychological well being;

- Strongbala Intensive Alcohol Program (SIAP) – this five day highly structured comprehensive alcohol program is provided to all clients who are court mandated to attend the Strongbala Justice Program. The clients must complete all units of the program and are provided with a Certificate of Attendance. All units offered in this program are based on CBT;

- Strong Family, Strong Mind program – this program is run in one of the town communities where there are high levels of family related alcohol issues, high levels of sniffing, high levels of alcohol related self harm and high levels of pregnant women who are identified as problem drinkers. This is a ‘community strengthening’ program with past evaluation providing positive feedback from participants as to the appropriateness of the program content;
- Targeted psychological services – these services are provided by a registered psychologist and are targeted at those clients identified as having a dual diagnosis (AOD and mental health issues) and who are on Mental Health Care Plan;

**Accessing the Service**

Clients can access this service by either referral or drop in.

**Waiting Periods**

There is currently a six week waiting period for clients presenting with serious mental health issues to access psychological services. The existing AOD program is considered as seriously under-resourced (one Coordinator and two Aboriginal AOD officers) and is struggling to respond to client referrals and the ever increasing demands for services and this has been exacerbated by an increase in visitors coming to town to drink as a result of the Intervention.

Waiting periods are determined by the admission intake process and priority needs of the referral. If the client presents as high risk the client will be given the appropriate response time given the available resources.

The manager works with clients referred from the courts pending sentencing and seeks to identify appropriate treatment alternatives. The waiting period for this service is 3 weeks.

If the client needs to access the services of the psychologist then there is a waiting period for approximately one month, unless clients present with serious cases such as suicide. In such cases clients are fast tracked or access emergency services due to no other options being available.

**Current Staff**

The AOD program includes a Team Leader and two Indigenous support workers. Staff run regular AOD programs for clients who are referred to them by the various programs within the area. They offer one-on-one counselling and case management. A psychologist is available for a total of three days per fortnight. There is already a sizeable waiting list for the services of these alcohol workers and it is thought that referrals from the tribunal will extend that waiting list substantially.

**Program Capacity**

The program reports that they are working beyond their capacity and will soon require more staff to work with clients who are on the “banned drinkers register”, SMART court and AOD tribunal. In January 2012 there were 62 clients on Wurli-
Wurlinjang’s AOD case list. Twenty-three of those clients have undergone assessment and various levels of intervention and the remaining 39 clients are waiting to be assessed for services. Seventeen of those clients presented with dual diagnosis issues and a further seven clients required referral for further assessment for Mental Health Care Plans and referral to psychological/AOD counselling.

- There are currently 39 Wurli AOD clients waiting to be assessed for service with 62 current clients being case managed by three staff which is unsustainable;

- There are 90 clients who would qualify for the Alcohol Tribunal if active, these clients would require clinical assessments, case management and support/counselling services;

- There is no intensive alcohol program in Katherine for Indigenous women, youth and at risk pregnant women;

- There are no AOD education and prevention programs provided for school aged children;

- There is a lack of services for clients who have completed mandatory treatment for volatile substance misuse (VSM) and who have been referred for further services. There have been in the vicinity of 18 VSM referrals to Wurli AOD this year. Katherine has the highest rate of volatile substance misuse in the NT per population with no dedicated staff to respond to this issue;

- There is a higher level of alcohol related protective custody arrests for 2011 in Katherine (7433) compared to Alice Springs (7,378) which has twice the population of Katherine. This is a totally non-serviced client area;

- WWHS report a massive 340% increase in service activity of the AOD program during the 2011 service period;

**Identified Staffing Needs**

WWHS reported that they need to recruit three additional therapists in the disciplines of social worker and psychology, two additional AOD support workers and one administration officer.

**Other identified Gaps**

Currently the program has 62 current clients who are being provided with a number of services which range from support through to intensive CBT. These clients are at varying levels of assessment and intervention.
The program is currently facing lengthy delays in delivering services to clients due to insufficient staff. Current delays in dealing with clients can be as long as four weeks. Such delays are having a twofold effect. Firstly clients do not get appropriate therapeutic care and are therefore being placed at risk of further deterioration due to AOD health related issues, and secondly there is the reduced inability to triage and assess new referrals coming to the service. Staff describe the program as being in a continual state of “backlog and catch-up”.

Staff believe that the reason for the significant increase in clients is due to an increase in the drinking population by people coming to town to drink as a result of the NT Intervention, and also because of what they describe as a “re-focusing and re-development” of the program in relation to key objective areas.

It is anticipated that with increased court referrals to the program as a result of the NTG Alcohol Tribunal client numbers will significantly increase during the 2012 service period. While it is difficult to estimate the exact rise in client numbers, staff reported that it would be prudent to expect an increase in client numbers somewhere in the vicinity of 100% over a 12 month period.

7.1.4 Katherine Hospital (Department of Health)

Katherine hospital is an accredited 60-bed non-specialist medical, diagnostic and treatment facility, which caters for the needs of the population of Katherine Town and District.

Accessing AOD services at the Hospital

In consultation with St John’s Ambulance Service it was stated that they estimate that 90% of their cases with Indigenous patients are alcohol related and generally either victims or perpetrators of domestic violence. Because of staff shortages at the hospital intoxicated clients are often placed in the Emergency Department (ED) waiting room because they are a lower priority than other more seriously ill patients. As a result of this and because of their intoxication they often exhibit inappropriate behaviour which results in being ejected by security staff. Additionally, as they are unsupervised and because of the long waiting period (up to 90 minutes for triage category 4), they may leave of their own volition. Either way this results in clients not receiving the treatment they require.

St John’s Ambulance Service have commented that an alternative place for these clients would be a good idea but resources at this time are unavailable.

Related Katherine AOD Stakeholders such as WWHS, MA and Kalano report difficulties in knowing how to refer clients to detoxification beds and how to collaborate with the hospital with regard to patients who are being discharged. Currently people go through the normal processes of being triaged and assessed
through the emergency department and categorised appropriately. Stakeholders are seeking more direct and efficient ways for clients to access this service.

AOD Service Capacity

- Detoxification/Withdrawal facilities were originally unavailable, however as a result of the NTER, funding for two beds was allocated and a temporary emergency response team was situated at the hospital to support these beds (Origin & Bowchung Consulting 2010). No specialist staff has been funded to support these beds or AOD services at the hospital. It was reported that these beds had an occupancy rate of 85% however the usage of them was not completely dedicated to alcohol withdrawal. Specific statistics on these beds in relation to AOD are difficult to determine. Staff report that the figures are low as most people arriving at the hospital in a highly inebriated state do not get further than the ED.

- The ED is the first contact point for people accessing the hospital. The ED has recently been upgraded. St. John’s Ambulance Service have indicated that in 2011 90% of their Aboriginal clientele have alcohol related presentations. The capacity of the Department is designed to assess and treat patients promptly before either admitting them or ensuring their safe leave. Currently, limited alcohol initiatives are in place and staff identifies the ED as having a role to play in creating effective outcomes for patients with AOD related issues.

- Discharge planning occurs for those clients that require this service. This is identified through morning doctor handover meetings, nursing and medical staff interactions with patients. Previous employees of the DoH AODP report there used to be a discharge meeting each week that would involve several services and seek to ensure patients leaving the hospital would have a coordinated continuity of care back into the community and home environment, setting up appropriate services and medication management. Currently a similar initiative takes place every week drawing on the relevant community stakeholders as needed.

- Nursing and medical consultations – alcohol and other drug related issues are identified informally with patients during the course of consultations. There is no formal routine screening for all the patients.

Identified Staffing Needs

Medical Staff
The HPP team, during a presentation of the project at the hospital, consulted with nine doctors. Their responses highlighted the high turnover of doctors which indicated only three had been at the Katherine Hospital for 12 months or more. Of the doctors interviewed four thought that between 40-60% of the clients/patients that attend the Katherine Hospital had issues related either directly or indirectly to
alcohol, while three thought it was between 60-80%. Four of the doctors interviewed suggested that they knew that 60-80% of their patients had returned to hospital in the time they had been there. When questioned if they felt they could effectively assist AOD patients only one doctor answered “yes”, while four answered “maybe”, and the remaining three answered “not really”. None of the surveyed participants were able to name five services in Katherine that they could refer a client with AOD issues to.

Nursing Staff
The HHP team also interviewed the nursing staff working on the Jack Roney Ward at Katherine Hospital. This was done over a period of several months late in 2011 whilst facilitating the Katherine Hospital Information Sharing Initiative (KHISI). Here services are invited to come to the hospital and provide informal presentations to ward nurses about their service. At the start of the initiative 59% of the nurses interviewed reported they knew “nothing to not very much” about the alcohol related services in the Katherine region. Following attendance at the session 89% of all staff stated that they had a better understanding about the services offered in Katherine. In addition 82% of the nursing staff found that these services relate ‘high’ to ‘very high’ to the needs of their patients. As a result of the HPP and KHISI, a post program evaluation showed that all of the nursing staff felt that they had a ‘moderate’ to ‘very high’ ability to refer patients to the presenting AOD services and 84% of all nursing staff surveyed indicated the benefit in having services come to hospital to share information on a regular basis to staff was ‘high’ to ‘very high’.

AOD Specific Staff
In 2007, in response to the expected demand for alcohol treatment services as a result of the NTER, the commonwealth government funded a “response team” for a period of six weeks. This team was led by a senior drug and alcohol clinician, and in addition comprised of a clinician specialist in alcohol and other drugs, a, nurse and counsellor. Their roles included

- Clinical management of clients undergoing alcohol detoxification and withdrawal;
- Training and education in clinical management of detoxification best practice procedures and protocols to the Katherine hospital workforce and local health providers; and
- Health promotion, prevention and networking in the local communities;

Feedback from the teams highlighted the cultural change within the hospital from alcohol related presentations where staff had become ‘desensitised’ to alcohol as an element of patients’ conditions, and tended to treat only presenting conditions. Venndale Rehabilitation Center reported a surge in referrals from the hospital during the period when the response team was present. These referrals were made by the response team and unfortunately the frequency of referrals then declined to pre-team levels when the team left (Origin & Bowchung Consulting, 2010).
Other Staff
Based on the size of the hospital 2 social workers and 2 Aboriginal Liaison Officers (ALO) (male and female) would normally be available, currently there is only one of each and both are female.

Proposed Initiatives

Discussions between the HPP team and the Medical Director have identified the need for a new approach regarding alcohol related initiatives at the hospital. These initiatives can be broken down into four main areas.

1. To be able to identify and record all patients presenting to the ED with either direct or indirect alcohol related issues. This would be done through surveys and would provide statistical clarity regarding the need for resources. Ultimately ensuring the hospital has a greater capacity to analyse trends in order to formulate appropriate internal processes;

2. To involve the relevant alcohol related community services in case-conferencing for patients who are admitted to the hospital and may have multiple and complex issues needing ongoing management post discharge. The idea is to ensure that successful initiatives would be developed through collaborative approaches, where feedback about the patients healing pathways could be evaluated from the withdrawal process through to rehabilitation and community support stage;

3. To evaluate whether these handovers to community services have been successful and conversely where the barriers exist in periods 3, 6 and 12 month post discharge;

4. To ensure all patients are formally screened and assessed for risk both medically and in relation to their well being. The risk assessment would incorporate various measures to determine risk from medical test results, information gathered from consultations and surveys by nursing and allied health staff. The categories of risk would determine what follow up action would be needed, i.e. further medical support or/access linkage to relevant service. Data obtained from these screening and risk assessments would contribute to the lack of statistical information highlighting the significance and seriousness of presentations to the Katherine hospital. Screening for excessive alcohol consumptions, followed by advice and/or counselling for those drinking hazardously to reduce their consumption, has been shown to be cost effective in reducing both alcohol consumption and alcohol-related harm (Kaner, Beyer, Dickinson, Pienaar, Campbell, Schlesinger et al, 2007).
7.1.5 Sobering up Shelter (SUS) Yarralah – Mission Australia

Yarralah is the Indigenous name of Mission Australia’s Sobering Up Shelter Katherine. The facility is located on Gorge Road and the facilities are designed to provide a safe place for people who are moderate to highly intoxicated to recover from the effects of alcohol or other drugs. The SUS offers facilities such as showers, laundry, beds, light meals, vitamin B supplement and has the capacity to carry out Brief Interventions. It is designed to protect people from assaults and exploitation while under the influence but also to reduce harm they may cause to themselves and to others.

The facility is open from 4pm until 8am the following morning. At other times the facility is closed and not resourced for any other AOD initiatives. A recent development has allowed Yarralah to invite other service providers to come to the facility and attend to any of their clients’ needs before they leave in the mornings. The best time for service providers to visit was stated to be between 5 and 7 am.

Clients generally arrive from around 4pm onwards, minimum stay is meant to be 6hrs but staff cannot force clients to stay who want to leave earlier. The majority of clients shower, have breakfast and get clean clothes in the earlier hours of the morning. Police will drop people off at Yarralah if they cannot find a sober person at the identified place of residence. It is assumed the facility fills up quickly later in the night. However, due to people leaving at different times, there are often beds that aren’t being used. From Friday through till Sunday the facility is generally at full capacity.

Limitations

The overall capacity of the facility is 24 beds although it is currently funded for 18. As a result this leaves a dorm room available and has the potential to be used as a meeting space. The facility includes a dining room with seating capacity for twelve.

Program capacity

The capacity of the current service is restricted by the current management model which restricts a manager to oversee and supervise the activities of the SUS workers to ensure operational actions are being conducted effectively. This is because the current position is split between overseeing the management of both the ICMS and the SUS program. The current model also restricts the ability of staff to engage in the morning with clients because they need to prepare the facility for reopening at 4pm and complete their respective tasks before the facility closes at 8am. The morning period between 5am and 7am is seen as the best time to engage with clients when they are sober enough for them to provide brief interventions, motivational interviewing and, referral to other appropriate services.
Current Staff

- 1 coordinator
- 6 fulltime permanent staff
- 1 to 2 casual staff

Staffing Requirements

Mission Australia identifies the absence of mental health and AOD specific counsellors at the SUS in the mornings as a deficiency. This limits the capacity of the service to work with clients to reduce harm and risk levels and either provide appropriate counselling service or link them to follow up services. They have identified the need to formalise staff skills to include MI and BI training.

Identified Gaps

SUS have reported issues with the staffing capacity to provide the assessments, brief interventions and referrals and this is due to the limited number of staff available who also need to carry out duties to ensure the smooth running of the facility. There is the acknowledgement that creating more referrals by the staff at Yarralah by performing BI and MI, that this will create even more stress on Venndale Rehabilitation Centre that already has a minimum waiting period of 4-6 months.

There is a need for alternative places to be made available for these clients if they request or accept a referral.

There is no service that can work with SUS clients from 5am onwards and assist them to access another service post SUS, such as Venndale, VTAC or Strongbala.

The SUS facility is currently not open during day hours 8am – 4pm. There is the potential for this facility to be used as a drop in center for those who need an access point to services during day hours. Further investigation of the usefulness of the facility being used during day hours is required.

7.1.6 StrongBala Healthy 4 Life Program (WWHS)

The Strongbala facility located north of Katherine off the Stuart Highway adjacent to Kalano Community Association comprises of a large house that is converted and used for consultation, offices and recreational space. There are resources for various health, vocational and occupational programs. A large outside area with shading, traditional cooking pit and vegetable garden provide a space for vocational and cultural activities. The facility is within close proximity to the river and bush.
The Program

The Strongbala Male Health Program delivers primary health care and support services for Indigenous males in Katherine. The program:

- Supports primary health care for Aboriginal males in Katherine with a holistic approach to improving health, self esteem, cultural connections and opportunity
- Provides cultural and gender security and mentoring
- Provides opportunities for skill development and employment
- Works with funding agencies, service providers, and stakeholders to enable a transparent coordinated integrated program
- Implements robust policies and guidelines to ensure continuous qualitative improvement
- Ensures the evolving program model takes a needs-based and evidence-based approach

The Strongbala Intensive Alcohol Program (SIAP) is a five day highly structured comprehensive alcohol program and is provided to all clients who are court mandated to attend the Strongbala Justice Program. The clients must complete all units of the program and are provided with a Certificate of Attendance. All units offered in this program are based on CBT.

Strongbala currently runs a 13 week prevocational capacity building program that prepares clients for training and employment options linking them to local jobfind providers and local industry. WWHS recognise that many of their clients are at Strongbala for longer than 13 weeks and would like to have the capacity to provide a structured program to suit those staying on.

Health checks take place for all the men that attend the service. A doctor visits once a week and a male senior Aboriginal health worker and health coordinator who are there full time. Appropriate screening and assessment ensure the men access the level of health care they need.

The Justice program is for court mandated clients and provides a structured form of treatment and support options as an alternative to incarceration. This is a relatively new program. These clients access SIAP and Anger Management training conducted by the WWHS Well Being Unit.

Other Programs Strongbala clients can access include the:

- Healthy Activities Program which includes Market Garden, Nursery, Life skills, Arts & Craft, Music and Garden Furniture Production
- Cultural Revitalisation Program which includes Sessions with Council Elders, Cultural Activities, Dancing, Hunting, Fishing, Bush Tucker, Cultural Food
Preparation, Material Gathering

Access to Service

The service is accessed through:
- Court orders
- Pick up from transport service
- Drop in and word of mouth
- Referral

Waiting periods

Currently the program has around 30-60 people attending daily, Fridays are generally quieter. There is no waiting periods to access the program, however there are limited spots per program and only a limited number of health checks can be performed in a day.

Staffing

It is staffed regularly by a RN clinic co-ordinator and 2 Aboriginal health workers and a receptionist. A doctor attends each Thursday. There are a total of 15 on the staffing list at Strongbala.

Identified staffing needs

The Strongbala manager stated that there was a need to counsel the men whilst at Strongbala and help them work through identified issues, including those related to mental health. At present there is no-one to fulfill this role and it is felt that there is need for a psychologist onsite. While this may not be feasible certainly a trained counsellor is required.

The Strongbala Intensive Alcohol Program delivers a lot of information in a short time and the current design leaves it up to the client to seek follow up. This is a perceived gap in service delivery. To remedy this, it has been proposed that the program be complimented by follow up education sessions that can better map the clients’ alcohol management journey. At present it is envisaged that one or two additional education sessions per week, approximately lasting 30-60 minutes in duration would be appropriate.

Other identified Gaps

More than half of Strongbala clients identify their home as being from regional areas surrounding Katherine and currently there are no formal pathways for these people to return home. There is currently no initiative that links in with these men to ensure a safe and supported return to their community. It has been commented by
the Justice Program Officer that “Issues of payback and blackfella law are awaiting them and that’s worse than facing whitefella law”.

Linking to local industry – although Strongbala have had some success in this area there is still a recognised gap in linking people to ‘a collective local industry initiative’.

In Katherine and the region the absence of a coordinated partnership between human services and local business and industries prevents the opportunity for people moving through healing pathways to engage in vocational and occupational outcomes and to ultimately improve socio-economic standards.

7.1.7 Ormond House (Men’s Crisis Accommodation)

Ormond house is a large residential style house that has office space, kitchen and eating area, recreational rooms, computer room and garden area. The facility can provide beds for up to 12 men and is currently undergoing extensions for another 2 rooms (2 beds). The facility has been constantly full since the current Manager has been working there which is since early 2010.

The Program

The facility is for men 18 and over who require accommodation that is either short term or longer term and provides:

- Alcohol and drug free accommodation for homeless men
- Life-skills guidance
- Support for jobs
- Mowing and cleaning service, cooking and cleaning within the house, a gym. program at the YMCA, and garden initiatives

In addition to this the program can also provide :
  - Case-Management to identify client goals and assisting clients to achieve these goals, which included referral to appropriate services
  - Support to people that are homeless, on disability pensions and with mild mental health issues
  - Transport services for clients

Access to Service

Ormond House has a referral document they encourage stakeholders to use, however Ormond house reports services are not cooperative in using this. It is reported to be more common for people to drop into Ormond house or make contact through another service.
Program capacity

Capacity is severely limited by the size of the establishment and was reportedly full for the last three years.

Waiting Periods

This is hard to determine as it depends when clients are ready to move on. However there has always been a waiting period given the facility has been operating at capacity. A waiting list has been active that lists people who could be ready to access the service if a client was to leave, the number on this list was not completely representative of those wanting to access the service overall. The manager commented that if the facility could accommodate a lot more people it would still function close to or at capacity, the need for this service is very apparent.

Staffing

- Manager
- Support Worker
- Care-taker

Identified staffing needs

Given the current setup of the facility and service current staffing needs are seen as adequate.

It was commented by the manager that having a mental health worker would be beneficial to enable them to work with higher needs clients who were experiencing mental health issues. However this would not have any impact on whether they could accommodate these clients since the care taker would also have to be capable of working with higher level mental health clients.

Other Identified Gaps

No short term affordable accommodation - most clients accessing this service are transients requiring short term affordable accommodation which is otherwise not available.

Very long waiting times for permanent dwellings – there are small number of clients accessing Ormond House who seek to be housed in permanent dwellings and are on long waiting lists. Currently there are several people accessing the service who have been waiting for housing options and have been doing so for over one year. The department of housing waiting list in Katherine currently stands at two years.
As stated by the Manager:

Many of the homeless people accessing Ormond house are very aware of how to live in a homeless environment including which services to access for any of their needs, here in Katherine and outside the town. There is a recognised contingent of people that are homeless and not wanting to change their way of living. This may be for a number of reasons however there is a feeling that some services enable people to live this way rather than taking responsibility to ensure better outcomes for themselves.

7.1.8 Women’s Crisis Center

The Women’s Crisis Centre (WCC) includes a residential styled house that is used for administration and management purposes and includes a conference room for versatility and training needs. In a separate but adjoining structure a facility for accommodating clients exists. This comprises of 5 self contained units (includes large and small units) which have shared living facilities.

The facility has a capacity of 25 beds and is security conscious with safety measures that ensure the protection and safety of the women and children attending the Center.

Limitations

The facility is severely limited by its size and has been operating at full capacity for the last year. It was estimated by staff that if another 30 beds were made available they would be occupied, as the need is so great for the service.

The Program

Clients are offered either support for unforeseen domestic violence related issues or requiring accommodation 24 hours a day. Generally it is a short term service where normally there is a client turn over every 3-5 days, however more recently clients are staying longer and up to about one month. The program can allow for funded crisis accommodation clients to stay up to 3months.

For those not requiring crisis accommodation there are programs focusing on education and support that can be accessed during the day.

Staff report seeing a number of the same women and children attending the service and although this is not large there needs to be a focus on the program to prevent domestic violence instances for those discharged from the program.

Access to Service

People access the Women’s Crisis Centre by just turning up. It is not possible to make a booking but rather call or turn up to the facility. Women aged 16 years or
older qualify for this service. Male children 15 years or older cannot access the service.

Program Capacity

Case-management - the program has a structured case-management component and is available for clients, those clients accessing the service for more than 2 weeks are reviewed on a fortnightly basis. Staff consider clients to be at the first stage of a referral pathway and these referrals typically go to the police, Katherine hospital or WWHS.

Counselling - male and female domestic violence counsellors are funded to work with clients and their families. Acquiring staff for these positions has been a challenge.

Physiotherapy - A physiotherapist works with clients to address issues related to domestic violence.

Education and Training - Other community based services come and work with the service to provide training and education and attend to any clients needs as recognised.

Waiting periods

The WCC is a drop-in center and therefore if the facility is full the person cannot access it. In the event of this happening the center tries to maintain contact with the person until there is a vacant bed. The person may attend during the day to access required programs.

Current Staff

There are twelve staff members in total and these are split between the main house area (5) and the unit area (7) The main house includes management, administration, domestic violence (both male and female) and other staff, and the Unit area where the case-managers operate.

Identified Staffing needs

Childrens’ workers – having the capacity to work closely with the children who also access the center through their mothers, has been recognised as a resourcing issue. Given these children are still developing and being exposed to domestic violence, the work would focus on reducing/treating the impact of vicarious or direct abuse and improving the protective measures for these children, which if unmanaged can have significant longer term health and social outcomes.
Other Identified Gaps

Outreach work – a significant resourcing issue recognised by the WCC is the absence of outreach services in Katherine that are available to work with the families who have previously accessed the center. Outreach workers could provide consistent monitoring and work within the home environment, which is expected to impact on the degree and frequency of domestic violence incidences.

7.1.9 Intervention Case-Management Services (ICMS) (Mission Australia)

ICMS is funded to provide case-management and logistical support to individuals at risk. The broad funding parameters allow the service to be involved in homelessness, displacement and anti-social behavior and there is sufficient leeway to engage in the many factors, such as alcohol, gambling, violence of all forms, family dysfunction, which is often the cause of homelessness and anti-social behaviour. This is intervention is both a street-based outreach and office-based service with frontline capabilities that can provide brief interventions, referral and linking to other services. The service also has transport capabilities.

The Program

The program can:

1. Find short-term and crisis accommodation
2. Locate and organise long-term accommodation
3. Identify and facilitate suitable referrals to other social services in Katherine
4. Provide transport for clients to appointments required to resolve their specific needs
5. Prepare alcohol management and public safety plans

Program Capacity

- Case-management capacity - basic level case-management services are provided to clients. This includes arranging crisis accommodation and transport to appointments and to attend counselling sessions. If clients live in Katherine transport home can also be arranged;
- Outreach and Logistical Support - undertakes daily vehicular and foot patrols at least twice a day in the Katherine area, Monday-Friday. Provides transport for clients to and from relevant appointments which are to the wellbeing of the client in areas such as medical, legal and housing;
- 'Return to Country' (RTC) - RTC assists clients who wish to return to their home communities. The repayment of cost is negotiated with the client and facilitated through Centre Pay deductions;
- Prisoner Post-Release Support program aims to facilitate a smooth transition for clients from prison, back into the community;
**Accessing the Service**

Clients access the service through informal referral and word of mouth but are mainly “walk-ins” to the Mission Australia office. Access is also gained via exposure to the outreach patrols run by the service.

**Staff**

Staff include:
- One coordinator
- Three case-workers.

**Identified Staffing Needs**

Mission Australia indicate ICMS is limited in providing a therapeutic component to their service because of their outreach focus and limited staff. The recommended client ratio per staff member is the Coordinator has 20-40 clients and each case-worker has 40-60 clients. It was noted that a registered counsellor in one of the relevant areas, for example Family/Relationship, Mental Health, Alcohol and Other Drugs would be a significant boost in services capacity. The Katherine Regional Services Manager stated:

If ICMS had more staff they could do more of the patrols, transporting and RTC. Just as with most, if not all, funded programs staffing numbers mean there is no excess capacity. If someone is sick, on leave or we are waiting to recruit a replacement the flexibility and capacity to respond and offer the same level of service will be challenged until numbers return to normal.

**Waiting Periods**

ICMS service is currently involved with between 125 and 140 clients. Generally clients can wait their turn or appointments can be made within one or two days.

**Identified Gaps**

ICMS are seen to be a linking service to other services and to provide basic case-management services. Efforts between Mission Australia, Venndale and the Healing Pathways Project concluded that to create effective pathways for clients leaving the Sobering Up Shelter (5am-7am) a service, exactly like the ICMS, needs to be operational to directly link SUS clients to VTAC, Venndale or other services like Strongbala.

If the ICSM had greater resources they could assist in filling some of the service gaps by providing an ‘outreach support service’ to clients who have accessed an
AOD related service and would benefit from broader more structured case-management and ongoing support/treatment.

7.2 Regional Programs

7.2.1 Alcohol and Other Drugs Program (AODP) – Department of Health (covers Katherine and Katherine regions)

The Program

The DOH AODP is a combination of services that includes working at the individual, group and community level. Assessment, counselling, training, education and research are a focus of the program. The program works with clients mainly from Katherine, but includes supporting regional communities and the services accessing them. Training and education is provided to support the local workforce and offers courses at single module topics and at certificate levels.

Assessment and Counselling - Counselling is holistic and focuses on all aspects of people’s experiences. Referrals need to be AOD related, including either people with harmful use issues and/or families and friends of people with the harmful use of substances issues. Assessment and counselling around the harmful use of alcohol is part of a case-management approach.

The program can work with families, couples and individuals, both in town and in the East and West regions. Following initial consultations that have been in person AOD counselling can be done over the phone, and includes follow up sessions, also over the phone.

Community Support - This is delivered through community workshops and information sessions that relate to AOD issues. Community support from the program can work in Katherine and also regionally and support is identified through the community. Education and information is delivered on AOD, and includes tobacco, smoking cessation and volatile substances. A focus is on health promotion and includes attending festivals to promote and deliver health promotion messages. The program works with communities to develop management plans to deal with the harmful use of volatile substances.

Training

The AODP offers nationally accredited training in Certificate II and Certificate III Community Services and Certificate IV in Alcohol and other Drugs and is fully funded by the NTG and offered at no cost. The training consists of a variety of learning methods ranging from completing workbooks to on-the-job training. It is self paced although it is recommended that training should take a maximum of 18 months.
Access to Service

The AODP can travel to remote communities, but currently it has a very limited capacity to do so. Staff have identified the need to do more in supporting staff at remote locations so that the work is more sustainable and staff can continually be supported and up-skilled. Telephone counselling has been used as a method to continue support from initial consultations.

Both SHSAC and KWHB have program coordinators that can provide AOD counselling remotely. The AODP reported that they could support AOD workers that would be based and work on communities.

For training opportunities, contact is made directly through the Department office in Katherine.

Staff

Staff includes:

- One Counsellor/Community Support Education Officer
- One Community Support Education Research Officer
- One AODP trainer

Identified Staffing Needs

There is enough need recognised within the program for a second counsellor/community worker and office space to accommodate this worker.

The program counsellor has identified the need for each community to have greater access to community AOD counsellor/support workers. Further investigation would be required to appropriately determine the needs of all communities, however greater access to mental health and AOD support has been recognised.

Waiting Periods

There is on average a one week waiting period for counselling and community support services due to this position having other duties to perform.

Identified gaps

The AODP recognised the very limited and case-by-case capacity to work with youth in the region. With the exception of very limited SHSAC Wugularr Youth at Risk Program there is currently no other service in the Katherine region that provides Alcohol and Other Drug/Mental Health youth specific services. More capacity to work with Youth around the harmful use of alcohol and drug issues has been identified.
7.2.2 Alcohol Tobacco and other Drugs Program (ATODP) – KWHB (covers Katherine West)

The Program

The program covers a region of 162,000km’s West of Katherine and seven remote communities in total, with the furthest community from Katherine being Lajamanu, which is 580km from Katherine. The ATODP is essentially an outreach program to Indigenous people on communities in the West Region of Katherine. It seeks to understand alcohol related issues and works at preventative measures and responds to existing issues. The Central Australian Rural Practitioners Association (CARPA) manual acts as a guide to the alcohol intervention and treatment protocols in clinical settings in Katherine West communities.

The main focus is providing Brief Interventions to people who are either accessing the health clinic or have been referred to the program. The coordinator follows up with clients that have been flagged by the clinics, health workers or other services including those in town.

AOD education and health promotion is delivered during community visits as a team approach that works in conjunction with other programs and practitioners.

As an outreach service the program routinely visits its communities in this capacity.

Access to the Program

For those living in remote communities, direct access to the ATODP coordinator is determined by when the program travels to a community. Often the KWHB teams will visit communities as a group. Depending on weather conditions, sorry business and other community related issues the program can visit each community in what they describe as “a handful of times per year”. With the absence of any community based workers, any AOD work is done through the community clinic workers or through liaison with coordinator via telephone.

Clients accessing Katherine West community clinics are routinely screened with medical checks and given brief interventions were AOD related issues are identified. Referrals are then sent to the ATODP coordinator who seeks to establish support and put treatment protocols in place. There are then follow-ups with clients during the next community visit.

Residents from the Katherine West region accessing services in Katherine are referred to the AOD coordinator by other services. The coordinator can then determine the appropriate support options available to assist the client and be supported by their community on their return.
Staff

Staff includes:
- One AOD Program Coordinator
- Two AOD Clinicians (currently not filled)

Identified Staffing Needs

The plan for the program is to have staff based at the remote clinics trained in providing brief interventions and support the staff to effect positive change in the clients. The AOD program reported that the challenge to effecting this is staff turnover and the capacity to frequently deliver training.

The program has the capacity to recruit two Indigenous AOD clinicians, these positions are currently vacant and it has been an impossible challenge for Katherine West to recruit to these positions. Further issues identified relate to the challenges of developing pathways for community members to be trained and remain working in the community.

Having community based support workers with the capacity to provide AOD/MH services is a key need for the program. Issues surrounding this include the challenges of training, retaining and supporting people to stay on the communities and work in an environment of conflicting interests, personal, family and related cultural issues, limited professional personal and professional support.

Limited access to mental health and AOD support workers challenges the service to provide more direct access to service and support for clients living in communities.

Other Identified Gaps

- No structured regional pathway exists for clients coming out of town based services and wanting to return and be supported in the community;
- Limited occupational opportunities, support resources i.e. service capacity and infrastructure;
- Limited ability to support mandated/court/tribunal ordered people on communities;

7.2.3. Sunrise Health service Aboriginal Corporation (SHSAC) (covers Katherine East)

The region covered by SHSAC is an area of approximately 75,000 square kilometres and includes the communities of Manyallaluk, Barunga, Wugularr, Bulman, Mataranka, Jilkmingan, Minyerrei, Urapunga and Ngukurr and their outstations. It was stated by the CEO that Sunrise Health Service is not funded to provide direct substance misuse rehabilitation and prevention programs although the need to do so is evident. He also stated that:
We are however, able to provide community based culturally appropriate education and awareness programs, immediate clinical treatment of withdrawal symptoms, and advocating on behalf of clients.

The Program

The service runs two relevant programs which is currently funded through the Department of Health & Ageing. The first is the Wugularr Youth at Risk Program which has one dedicated worker. The program which has been extended to Jilkmingan with plans to include Ngukurr, includes as one of its harm reduction strategies, delivering volatile and other substance training to parents and significant others.

The second program is the Tobacco Control and Other Substances Program, which is run by one Aboriginal Health Worker. The aim of the program is to:

Deliver effective and culturally appropriate drug and alcohol services and programs within the SHS communities to improve the health and wellbeing of its community members.

This is achieved through the following strategies:

- Implementing and maintaining community based education and prevention activities such as programs to address lifestyle risk factors such as alcohol/substance abuse;
- Implementing and maintaining a social and emotional wellbeing service through support, counselling and harm minimisation programs (delivered to individuals and family groups);
- Providing clinical treatment and supporting clients undergoing detoxification/withdrawal from substance use;
- Participation in intersectorial collaboration with other service providers to address substance abuse issues through established networks;
- Providing therapy to clients referred from a variety of pathways including self-referrals and family intervention;

Current Staff

- One Social and Emotional Wellbeing coordinator
- One Youth Preventative Program Coordinator

Limitations

In order to increase their AOD services to more adequately address the needs of their clients in this area the service has recently submitted bids to the DH&A for the implementation of regional programs in Chronic Disease and Substance Misuse.
8.0 Issues with service delivery

This section is divided into four sections and analyses the information from the previous sections. Issues are discussed under four categories, namely:

1. Issues related to infrastructure
2. Issues with access to services
3. Shortfalls in the capacity of services
4. Shortfalls related to continuity of care

8.1 Issues related to infrastructure

The review of infrastructure and respective services indicates that much of the current infrastructure is adequate to meet current needs. The exception to this is the crisis accommodation for both men and women. The Ormond House men’s accommodation facility is severely restricted by its size and has been constantly full for the last three years. Similarly the Women’s Crisis Centre which has a capacity of 25 beds has been operating at full capacity for the last year. It was estimated by staff another 30 beds would be occupied given the need is so great for the service indicating that service delivery is hampered by lack of infrastructure.

8.2 Issues with access to services

Access to service is either voluntary or mandated. Voluntary access by self referral (“drop-ins”) or by service referrals and community clinics. Clients accessing services by this means is through informal processes, which depend on the staff working within a service and their relationship with another service. However the number of clients accessing services in Katherine as a result of self referral or referral from another service is reported to be very small.

The majority of clients accessing alcohol related services in Katherine are mandated to attend. Clients access SUS and Police Custody through encounters with the Community Patrol and the Police. Legal services including NAAJA and Correctional Services organise treatment options for clients who make up the majority of attendees at Venndale Rehabilitation, Wurli-Wurlinjang AOD and the Strongbala program. There is very little collected data, statistics or other evidence to analyse trends or referral pathways.

Access to regional services is limited by the few resources available. Regional services are supplied by the Department of Health AODP, SHSAC in the Katherine East region, and KWHB in the Katherine West region. The AODP can travel to remote communities, but currently it has a very limited capacity to do so. Staff have identified the need to do more in supporting staff at remote locations so that the work is more sustainable and staff can continually be supported and up-skilled.
Telephone counselling has been used as a method to continue support from initial consultations.

The recent changes to legislation through *The Alcohol Reform Act 2011* has seen the introduction of compulsory treatment provisions for problem drinkers and has introduced the SMART Court and AOD Tribunal. There is also the anticipated Community Based Orders and Community Custody Orders in 2012 which can mandate rehabilitation. The effect of this has been to place a focus on treatment rather than prevention. It should be noted that regional AOD services are focused on prevention and were not set up to deal with clients going through the legal justice process who are mandated for treatment.

The number of alcohol related offences within communities is reportedly large. The Northern Territory Community Correctional Services (NTCCS) stated that in a regional breakdown of NTCCS clients indicates that approximately 50-55% are regional and over 50% of all offenders committed their offences under the influence of alcohol. From a recent snapshot of cases approximately 70% of current offenders committed their offences under the influence of alcohol, and alcohol is flagged as a persistent risk factor for this group of offenders.

NAAJA, who deal with the "bush court" sessions, require services that accommodate their sentenced clients from a treatment perspective. These services are only available in regional centres, which places added stress on them.

### 8.3 Shortfalls in the capacity of services

In every service examined the shortfalls in capacity to accommodate clients was identified as inadequate resourcing in the area of funding and staff. The inability to recruit and retain staff placed additional strains on remaining staff and limited processing caseload. All agencies identified the need for a significant boost in having specialist staff available to work with their clients.

Below is a dot point summery by service concerning access issues:

**Venndale Rehabilitation Centre**

- Continually full – often refusing referrals (waiting list 4-6mths)
- No qualified counselling services at Venndale and or MH support onsite (using WWHS/AOD resources when available)
- Unable to meet the demand to provide service to youth and families.
- No medical support on site
- Limited transport, administration, outreach capabilities
- Recruitment/retention of staff including qualified Aboriginal staff
- Volatile Substance treatment facility.
Venndale Transitional After Care

- Limited case-management
- Life skills coordinator & program available at evenings
- No transport
- No specialist staff
- Lack of support for clients at home post care
- Larger facility required than the current 10 beds

Sobering up Shelter

- Linking clients to services at opportune times (5am -7am) – no services are available
- No specialist staff to work with clients
- No staffing capacity to assess/counsel/refer clients
- Functions at capacity Thurs – Sun
- Facility not being used at the SUS during 8am-4pm

Wurli-Wurlinjang Aboriginal Health Clinic

- Clinical services at WWHS are operating at capacity
- Clients on alcohol tribunal orders will not be able to access services given services are already stretched
- Long waiting periods to have assessments from clinicians
- Environment of inadequate staffing and resourcing, subjects staff to extreme stress
- Venndale clients needing GP assessment endure long waiting periods and often leave before assessment, this has further health implications

Women’s Crisis Centre

- Continually full over the last 12mths (can only accept drop ins)
- No outreach/follow up capacity to ensure ongoing support
- Limited capacity to work with children accessing service

Ormond House

- Continually full over the last 24mths
- No short-term affordable accommodation
- Often cannot accept people
- No specialist staff to work with clients
- Those seeking government supported permanent dwellings are required to wait 2 years
Wurli AOD Program

- Lack of regional treatment options having a huge impact on Wurli AOD program
- 6 week wait for MH services
- 3 week wait for court ordered clients
- Severely understaffed - require 3 qualified therapists, 2 additional support workers to meet service demands.
- KIARG – no community based workers - the need for 10 Aboriginal workers who are managed and mentored by an Aboriginal program coordinator and support / training officers (male and female)

Katherine Hospital

- High staff turnover, especially GP's
- Limited staff awareness and knowledge of community services and referral pathways
- Limited data available to indicate direct/indirect AOD related presentations to ED
- Absence of formal screening and assessment of all patients
- The need for case-conferences involving community based services for complex clients
- No recognised processes for clients wanting to withdraw
- The need for AOD specialist staff on site

Department of Health AODP

- Very limited capacity to work with youth
- Limited capacity to work both regionally/remotely
- Identified need for another full time counsellor in Katherine

Intervention Case Management Services

- Restricted by staffing numbers and levels
- Restricted by hours of operation
- Limited outreach capacity
- Limited structured case-management capacity

Wurli – StrongBala

- No specialist counselling staff on site
- Limited ability to follow up with clients who participated in alcohol treatment/education sessions for evaluation purposes
- Limited capacity to work link clients to regional services to ensure support return to community
- Lack of coordination with local industry to ensure occupational/vocational outcomes can exist

**KWHB-ATOD Program**

- Limited AOD treatment capacity with 1 staff running the program for the region
- Issue of recruitment and retention (2 funded positions that are not filled)
- No accessible region wide alcohol treatment options
- Issues linking clients to treatment in town and then ensuring supported return

**SHSAC**

- Not funded to provide direct substance misuse rehabilitation and prevention programs, however community-based education programs are provided.

### 8.4 Shortfalls related to continuity of care

Continuity of care is one of the major deficiencies in the successful treatment of clients. There appears to be no formal referral pathways and little in the way of discharge planning. In the period 2009 to 2010 consultations with key stakeholders informed the Healing Pathways Project of the following major issues relating to referrals and client handovers between services:

- Lack of continuity of care for clients accessing services
- No common effective referral tool
- Clients not accessing full range of services
- Services not being referred to
- Services not responding to referrals & being made accountable
- Little awareness of other services
- Services not adequately resourced
- Gaps in services and infrastructure
- Questionable inter-agency relationships

In more recent consultations between the HPP and stakeholders (2011/2012) in the Katherine region, services have admitted to having the attitude that to ensure the best outcomes for their clients they are reluctant to refer them to another service given they don’t know if the treatment will be successful elsewhere. This attitude combined with long waiting periods to services has ensured that interagency referrals numbers are very low. This is seen as due to the absence of any formal indicators measuring success for both the services and their clients having been established in the Katherine region. There is reportedly very little feedback and follow up to services about clients that have been referred on and little knowledge regarding how they have progressed, or what barriers they encountered, 3, 6 and 12 month post referral.
9.0 Current initiatives addressing service delivery issues

9.1 Katherine Indigenous Alcohol Reference Group (KIARG)

In response to extensive consultation with the Indigenous community of Katherine, WWHS received a strong mandate from Aboriginal Elders, community members and partner Aboriginal organisations to resource an Aboriginal body to exert authority and influence amongst Aboriginal and non-Aboriginal people in the management of alcohol in a culturally appropriate way in the Katherine region.

KIARG was set up to fulfill this role and members include Aboriginal Elders, youth and both male and female representatives.

These members were elected by communities via intensive community consultation to represent Aboriginal residents of all Katherine and surrounding areas, including Katherine town, Jodetluk, Geyulkgan Nguurra, Rockhole, Binjari, and Kalano/Mialli Brumby. Representation from KIARG will provide strategic oversight of and support to, a group of 10 Aboriginal workers who are managed and mentored by an Aboriginal program co-ordinator and support/training officers (male and female). They will work with professionally qualified AOD workers from the Wurli AOD program. As well as providing front line AOD support they will facilitate referrals for more formal individual and group programs. Community AOD workers and professionally qualified AOD workers will provide mutual mentoring and support, creating a cross cultural team working together to create better outcomes than either Aboriginal community workers, or professionally qualified non Aboriginal AOD workers, could achieve by working in isolation.

This model is designed to assist clients who, despite desperate need, resist utilising available services. Wurli has already established a successful peer support program (Strongbala) that has demonstrated the healing power of services provided by Aboriginal people to Aboriginal people. The model will:

- Enable successful and sustainable alcohol programs by creating a pool of Aboriginal Community Workers who are supported by their community, advised by elders and trained in specific AOD skills by qualified staff;
- Improve effectiveness and retention of non Aboriginal professional staff through providing improved cultural orientation as well as ongoing cultural mentoring and provision of culturally appropriate and enabled introductions to clients;
- Provide healing pathways for clients that enable the recent alcohol tribunals established to operate as envisioned;
- Assist clients to step onto and remain on the variety of healing pathways needed to address their alcohol issues;
- Create much needed Aboriginal jobs, training and career opportunities;
At the time of writing it was reported that Katherine’s Wurli Wurlinjang Aboriginal Corporation are to receive more than $832,000 funding to tackle alcohol and other drugs issues in the Katherine region as part of a $2.31 investment by the Australian Government. An unconfirmed report suggests that this funding will support the KIARG initiative.

### 9.2 KRAHRS Healing Pathways project

The KRAHRS Healing Pathways Project was initiated to identify gaps in service delivery, engage numerous service providers, facilitate community/client engagement and develop, implement and manage a coordinated model of culturally appropriate care facilitating the case management of clients to enable them to combat the impacts of alcohol on their lives, their families and their community. See Appendix 2 – The Gaps in Healing Pathways.

The Purpose of the project is to:

- work with stakeholders and service providers to coordinate the existing services
- develop an inclusive healing pathway
- develop applications to facilitate the necessary care through the pathway
- investigate the best method/s for addressing the identified gaps
- develop strategies to close the gaps

### 9.3 Other Initiatives

There are a number of current initiatives in the form of funding submissions which have been submitted to the relevant Government bodies in the recent round of grants. If these grants were successful they would go a long way to increasing resources in town and regionally, but most notably ensuring support would be available on communities (including town communities) and not deliver periodically from Katherine town. Submissions currently being assessed KRAHRS are aware of are listed below;

- WWHS - to provide AOD/MH community based workers and therapeutic staff to support the Katherine Indigenous Alcohol Reference Group (KIARG) to town based communities;

- SHS - to provide regional AOD/MH community based workers and therapeutic staff on all their remote communities;

- KRAHRS Healing Pathways Project - to continue to provide the coordination of services, advocacy efforts along with the implementation management and evaluation of the common case-management/referral tool;
The Department of Justice Pilot Program—The objective is to support people who have been ordered by the alcohol tribunal to undergo alcohol treatment. There has been $500,000 allocated for a 12 month pilot project to provide case support and coordination, once the Tribunal has mandated the client. This will build on the Healing Pathways model and be a coordinated regional approach. This includes linking in with people returning to or coming from remote communities. It includes not only coordinating treatment, but other supports identified in the order which includes monitoring progress/coordinating care. This project while a pilot for the Tribunal is also seen as supporting a strategy in the Katherine Alcohol Management Plan.

Gaps identified in this report that are within the mandate of the HPP objectives and therefore can be addressed at the local level are listed below:

- The development of formal screening and assessments processes;
- Defining referrals processes to case-managers for both alcohol related streams and substance misuse streams;
- Implementation/administration/evaluations of the common assessment tool and case-management/referral tool;
- Establishing formal links between towns based services and regional services;
- Establishing pathways from post treatment and rehabilitation to training, occupational and community integration opportunities;
- Establishing and developing collaboration between local industry/business to health related programs, both here in town and regionally;
- Research and investigate the appropriateness for all alcohol related services to agree to being evaluated periodically to determine if the treatment approach is ensuring successful outcomes in the most cost effective way;

10.0 Discussion

This document is seen as a work in progress, a stepping stone to further work. It is hoped this can be built on to help grow the resources needed to effectively address AOD related issues in the Katherine region. A limitation of this research is the absence of input from those people who have accessed AOD services, been mandated to treatment orders, are in town because of the greater access to alcohol and/or those who have returned to regional communities post treatment to understand their experience within interagency service delivery system. A similar experience was reported in the evaluation of the KAMP report regarding Aboriginal input on community views of Katherine’s AMP which consisted solely of a phone survey and indicated Aboriginal input constituted only 8.9% (d’Abbs et al 2010). As quoted in Bryant & Saxton et al (2008):

Consumer participation in planning and delivery of drug treatment services has been broadly endorsed by state and federal governments and within the
mental health experience it shows consumer involvement can work with groups of traditionally marginalized people.

One of the significant findings of this study was the considerable lack of knowledge that consumers had about the participation activities available to them. This then is one area that warrants further research.

An entity such as KIARG, is an initiative that needs to be supported, and can be instrumental in defining peoples’ experiences and provide a united voice with the authority to advocate for Aboriginal people’s needs in relation to AOD related issues and what the culturally appropriate responses should be.

The proposed community based workers linking into KIARG as outlined in a recent funding submission by WWHS clearly states:

This model is designed to address a context of culturally disengaged services provided to clients who, despite desperate need, resist utilising available services.

Gray, Saggers, Wilkes & Allsop (2010) found that while research into the treatment of alcohol-related problems among Indigenous Australians has been limited, it suggests that:

Interventions known to be effective in other populations cannot be assumed to effective in Indigenous populations; the evidence for the effectiveness of treatment is equivocal; and the provision of treatment in primary health care settings is less than optimal. Furthermore, treatment is complicated by high levels of comorbid mental health problems that, in turn, contribute to greater impairment and disability, higher health and other costs in the community, and result in poorer treatment outcomes than among individuals affected by a mental health disorder or drug problems in isolation (pp34).

There are some major questions to be asked in the Katherine region currently which are the concern of stakeholders and relate to how and if services are actually producing successful outcomes. How is success defined for both the service itself and also for client outcomes? Are these outcomes, whether they are successful or not, the most cost effective? Are the AOD practice standards they align with common amongst stakeholders, does the service even have practice standards they are guided by?

As far as the HPP understands there are no standards common amongst stakeholders and given the variety of funding streams into AOD services in the Katherine region, performance indicators, reporting standards, measures of success, service evaluations, quality improvements initiatives and auditing and accreditations are neither consistent or even exist amongst some services. Again all these questions are worthy of further research. Program review and evaluation should be high on the list.
Services in the Katherine region generally have the attitude that to ensure the best outcomes for their clients they are reluctant to refer them to another service as they are unsure if the treatment obtained will be successful elsewhere. A major reason is that there is no practice process in place amongst services that ensures services will provide feedback or discharging information to the referring service. The consequences of this is that organisations design their own internal pathways of care, which as they consider, will provide the best care options for clients given the available resources. The problem with this is obvious, not all the essential services are available at one organisation. This issue is a major objective of the HPP to address.

The major shortfalls in AOD related service delivery in the Katherine region fall into three categories:

1. Workforce capacity issues
2. Access issues related to limited services both in town and in regional areas
3. Issues relating to vocational or other “end stage” opportunities for clients
   For example community support and integration programs

**Workforce capacity issues**

There is a marked shortage of appropriately qualified staff for AOD related services in the Katherine region. Attracting, accommodating, and retaining qualified and specialist therapeutic staff is extremely difficult. For example at the time of writing there was one counsellor, one AOD counsellor, one Aboriginal mental health worker, one part time psychologist and one part time social worker in the AOD related sector, and no community based AOD related workers. High caseloads coupled with staff shortages put increasing pressure on remaining staff, many have to work beyond their capacity, for example acting in a position they are not qualified to do while attempting to do their own job. The result of this is frustration, burnout and resignation.

Although beyond the scope of this report it is worth noting that there is a shortage of properties to buy or rent in Katherine and prices and rents are generally high. Contracts offered, are generally of short duration and fixed term and controlled by funding parameters. Employees often have to travel quite long distance in difficult conditions to visit communities to engage with clients. All these issues discourage prospective employees from moving to Katherine and impact on service capacity.

**Access issues**

**Katherine**

Access to services is determined largely by the limited capacity of services to accommodate clients and by service policy. In Katherine there are a significant
number of people wanting to access AOD programs, rehabilitation and crisis accommodation who are unable to so because of the significantly long waiting periods. These are critical services in addressing the AOD related issues of the client. WWHS has probably the most comprehensive service and currently there is a six week waiting period for clients presenting with serious mental health issues who need to access psychological services, and the existing AOD program is considered to be seriously under-resourced.

There are no AOD related services, apart from the SUS and the hospital, that work after hours and are able to assist at these opportune times. The SUS cannot link people directly to rehabilitation, due to waiting periods for transport and access to GP’s for pre-admission medical checks, which are estimated to be one person per day. According to St John’s Ambulance most call out situations that are alcohol related and involve domestic violence and mental health issues mainly occur after 10pm when the services necessary to be involved are not accessible. There are also no emergency AOD/MH personnel available after hours to deal with clients once they have been discharged from the emergency services. The SUS, who may take clients after discharge, acknowledge the need for personnel who could give counselling in the early morning (5-7am).

Transport is another limiting factor to accessing services and while WWHS provides transport for clients within a 30 mile radius of Katherine other clients living in communities need to find transport and then accommodation in Katherine in order to access services.

**Katherine Region**

Access to Regional services is limited by the few resources available. Regional services are supplied by the Department of Health AODP, SHSAC in the Katherine East region, and KWHB in the Katherine West region. The AODP can travel to remote communities, but currently it has a very limited capacity to do so. Staff have identified the need to do more in supporting staff at remote locations so that the work is more sustainable and staff can continually be supported and up-skilled. Telephone counselling has been used as a method to continue support from initial consultations.

KWHB provides limited services to the communities of the Katherine West region and access to the service is determined by when the AOD program coordinator but visits the communities, which is a very limited number of times a year. SHSAC has a Tobacco Control and Other Substances Program which is run by one Aboriginal mental health worker and is also limited in scope.

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4 HPP and MA consultation late in 2011 reported the SUS has, on average, one person per day who would like to access further support such as rehabilitation when they leave the facility.
It should be noted that regional AOD services are focused on prevention with little or no capacity to deal with clients going through the legal justice process who are mandated for treatment.

**Vocational opportunities**

All services interviewed have highlighted the lack of vocational pathways for people exiting treatment options. The shortfalls in service capacity identified in this report indicate that there are significant challenges for anyone suffering from the adverse effects of alcohol and wanting to “heal”. Notable are the lack of resources available regionally and the lack of opportunities for people to participate in healthy vocational living in their home community. The employment opportunities on regional communities are virtually non-existent and there are no resources to support people returning to their community following treatment in town. Similarly in the town itself there is a real need for vocational pathways for clients exiting treatment options. This is proposed in the yet to be released KAMP 2012-2014:

> The focus for this employment initiative will be on employers in the town and region. Bringing together the private sector, through the Chamber of Commerce and Industry, both levels of Government, Aboriginal employers, Job Services Australia providers and Australian Employment Covenant, a plan will be developed to encourage and support local members to employ more young Katherine people (pp10).

Providing sound vocational pathways and meaning in people’s lives is really the key to stemming or at least reducing the “revolving door” syndrome that sees many clients in the endless cycle of being picked up by community control in an inebriated state, taken for treatment or sobering up, discharged, and again picked up by community control in an inebriated state.

**Other issues**

The effectiveness of a rehabilitation or counselling course needs to be complemented with family education so they can support the client through difficult periods. For many, the home environment poses immense challenges, including security of appropriate shelter, healthy food, clean water and sanitary living conditions, and pressure to start drinking excessively again. These basic needs, which are often unmet pose significant barriers to healing pathways for individuals.

The absence of any formal processes linking town and regional services is a barrier to the continuity of care options for clients who have accessed AOD related services in town and who are planning on returning to communities. An assumption exists amongst stakeholders that if regional areas had greater resources then town based services would not be as stressed as they currently are and this should be further examined.
This report highlights that if a collective group of services are going to try to address the harmful use of alcohol in a regional approach then regular and objective evaluations need to occur, and services need to be certain they are operating in a way that effectively coordinates with other services within the system. This is necessary to ensure the overall system is geared to produce optimal output in the form of the best level of care for the client.

Accreditation to standards is conducted within clinical and medical services and the aged-care sector but is not in the alcohol or mental health fields here in Katherine.

Previous attempts to understand and implement case-management across AOD sectors (The Nucleus Group, 2005) have recommended the need for:

- A sector wide systematic program of assessing service outcomes for clients based on current practices that agencies have found to be effective and useful;
- Implementing a sector wide systematic program of gathering mutual feedback from agencies;
- A sector wide systematic program of gathering feedback from clients would give the sector valuable information about their clients’ experiences of and attitudes to case-management;

It must be noted that in response to these particular issues, the HPP Project has been developing (in conjunction with key stakeholders) a web based case-management and referral tool specifically for improving best practice case-management and referral practices within the AOD sector of Katherine, and this will be available regionally. The website aims to streamline referral processes, increase engagement, accountability and provide feedback and statistical evidence to services themselves and to highlight how referral pathways are functioning and where the gaps are. The tool is expected to be operational before the financial year of 2012.

11.0 Conclusion

The review of infrastructure and respective services indicate that much of the current infrastructure is adequate to meet current needs. The exception to this is the crisis accommodation for both men and women. The men’s crisis facility, Ormond House, is severely restricted by its size and has been constantly full for the last three years. The manager commented that if the facility could accommodate a lot more people it would still function close to or at capacity and so the need to expand this is apparent. Similarly the Women’s Crisis Centre which has a capacity of 25 beds has been operating at full capacity for the last year. It was estimated by staff another 30 beds would be occupied given the need is so great for the service indicating that service delivery is hampered by lack of infrastructure.
In every other case the limiting factor was the level of resourcing in the area of funding and staff. All agencies identified the need for a significant boost in having specialist staff available to work with their clients.

This report concludes that significant gaps in service delivery and barriers to access exist in AOD related services in the Katherine region. There is a major issue concerning the capacity of services to provide an adequate level of care to clients. This is largely the result of the inability to recruit and retain appropriate staff and this in turn is partly the result of underfunding.

There appears to be no common standards amongst stakeholders in the form of performance indicators, reporting standards, and quality improvement initiatives. Services should be reviewed and programs evaluated to ensure interventions in place are having the desired effect and impact.

Service coordination and discharge planning needs particular attention. Earlier it was stated that there was no practice process in place amongst services that ensures those services will provide feedback or discharge information to the referring service. The consequences of this is that organisations work in isolation resulting in significant gaps in the continuity of care. This issue will be addressed under the HPP.

A significant gap in the service delivery continuum is that of severely limited options for clients recovering from the effects of alcohol dependence. There are no divisionary programs in place and little or no vocational pathways. As previously stated providing sound vocational pathways and meaning in people’s lives is really the key to stemming or at least reducing the “revolving door” syndrome. For many, alcohol is not the problem it is the solution to the problem of depression and hopelessness. Providing hope and a way forward in the form of vocational training is an important way in addressing this, for unless we can successfully address this issue we will never successfully address the “problem of alcohol”.

12.0 Recommendations

This document may be considered a base document highlighting service delivery shortfalls and gaps. The solutions to these issues are beyond the scope of this document and constitute the next phase of study. Nevertheless there are a number of suggestions and recommendations that can be made to guide this next phase.

There is a critical shortage of counsellors and personnel qualified in the areas of AOD and mental health disciplines identified by all services. It is recommended that services address this as matter of high priority. It may be necessary for services to collaborate to find a solution to this shortage, possibly through the medium of KRAHRS. Some thought should be given by services with extremely limited resources to exploring ways in which a counsellor may be shared, again KRAHRS may be able to auspice this initiative.
Ongoing and follow up care is essential in reducing the frequency of relapse (McLellan 2002). Unfortunately as Gray et al. (2010) notes there is a lack of such services for Indigenous Australians in the Katherine Region. This needs to be addressed in two ways, firstly by providing a home support service and secondly by developing vocational pathways and opportunities both for clients exiting treatment and as a divisionary preventative program. It is recommended that the above options be examined.

To address the shortfall in support to clients living in regional areas, it is recommended that a model to address this be developed. One workable option would be to have at least one health worker/project worker in each community with some basic training in mental health literacy and AOD counselling. These personnel should ideally be supported by a trained professional based in Katherine who has the ability to travel to remote communities as the need arises. Again it is recommended that services collaborate where appropriate to ensure the best outcomes. In conjunction with this KRAHRS research and investigate the appropriateness for all alcohol related services to agree to being evaluated periodically to determine if the treatment approach is ensuring successful outcomes in the most cost effective way.

There is a critical shortage of crises accommodation in Katherine which impacts severely on the health and wellbeing of the marginalized population of Katherine. Solutions to this need to be explored and it is recommended that options in addition to constructing further accommodation be considered.

There are extremely limited treatment options regionally and with the mandating of alcohol related offences, clients are required to travel to regional centres for treatment, putting additional strain on them. It is recommended that other options than formal residential care should be explored that could be run in the communities in a more appropriate way.

The absence of youth focused AOD services has been noted and it is recommended that this be addressed by developing appropriate resources for example KRAHRS Regional Youth Group.

Finally it is important that all options have a strong “bottom up” element and involve strong community input. In line with this it is advised that services be encouraged to take ownership of identified gaps and progress towards addressing these. While it is recognized that this is not always easy the newly formed KIARG could provide a strong lead in this area.
References


Hunter, E, Brown, J & McCulloch, B 2003, Encouraging practitioners to use resources: evaluation of the national implementation of a resource to improve the clinical management of alcohol-related problems in Indigenous primary care settings; Drug and Alcohol Review (23) pp 89–100.


Katherine Region Harmony Group 2007, Katherine Alcohol Management Plan: A Plan for Everyone. Draft for discussion only. Katherine Region Harmony Group


SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, Overcoming Indigenous Disadvantage: Key Indicators 2005, Productivity Commission,

### Appendix 1
List of services interviewed

<table>
<thead>
<tr>
<th></th>
<th>Service</th>
<th>Organisation</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Aboriginal Health/Medical Service</td>
<td>Wurli-Wurlinjarg Health Service</td>
<td>Medical Director</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol and Other Drugs Program &amp; Katherine Indigenous Alcohol Reference Group (KIARG)</td>
<td>Wurli-Wurlinjarg Health Service</td>
<td>Chief Executive Officer Manager Wellbeing Unit</td>
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<tr>
<td>3</td>
<td>Alcohol Tobacco and Other Drugs Program</td>
<td>Katherine West Health Board</td>
<td>Program Coordinator</td>
</tr>
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<td>4</td>
<td>Venndale Rehabilitation Centre</td>
<td>Kalano Community Association</td>
<td>Venndale Manager</td>
</tr>
<tr>
<td>5</td>
<td>Venndale Transitional After Care Facility</td>
<td>Kalano Community Association</td>
<td>Venndale Manager VTAC staff Member</td>
</tr>
<tr>
<td></td>
<td>East Regional Health Service</td>
<td>Sunrise Health Service</td>
<td>Chief Executive Officer Program Coordinator</td>
</tr>
<tr>
<td>6</td>
<td>Sobering Up Shelter</td>
<td>Mission Australia</td>
<td>Regional Service’s Manager Program Manager</td>
</tr>
<tr>
<td>7</td>
<td>Intervention Case-Management Service</td>
<td>Mission Australia</td>
<td>Regional Service’s Manager Program Manager</td>
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<td>8</td>
<td>Katherine Hospital</td>
<td>Dept of Health</td>
<td>Medical Director Social Worker Acting Director of Nursing Nursing Educator</td>
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<tr>
<td>9</td>
<td>Alcohol and Other Drugs Program</td>
<td>Dept of Health</td>
<td>Counsellor Training Coordinator Community Engagement</td>
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<td>10</td>
<td>Women’s Crisis Centre</td>
<td>Funded by the Dept of Health</td>
<td>Service Manager Case-Manager</td>
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<tr>
<td>11</td>
<td>Ormond House</td>
<td>St Vincent de Paul’s</td>
<td>Service Manager</td>
</tr>
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<td>12</td>
<td>Aboriginal Legal Service</td>
<td>Northern Australian Aboriginal Justice Agency</td>
<td>Senior Criminal Lawyer Criminal Lawyer</td>
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<tr>
<td>13</td>
<td>Strongbala Men’s Health</td>
<td>Wurli-Wurlinjarg Health Service</td>
<td>Medical Director Clinical Health Coordinator Justice Program Manager</td>
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<td>14</td>
<td>NT Community Corrections</td>
<td>Northern Territory Government</td>
<td>acting Regional Manager</td>
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<td>15</td>
<td>Katherine Magistrate</td>
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<td>Magistrate</td>
</tr>
<tr>
<td>16</td>
<td>Ambulance Service</td>
<td>St John’s</td>
<td>Paramedic</td>
</tr>
</tbody>
</table>
The Gaps in Katherine’s Healing Pathways

Entering the Pathway

- No defined/formal referral processes to case-managers, including regionally
- No formal routine screening to all patients at the hospital to assess risk
- Limited staffing capacity at SUS to do screening & assessments, referrals
- Lack of appropriate AOD/MH services working outside 8am-5pm
- No common risk assessment tool that ensures person is linked to relevant service
- Limited to no crises/short term accom support options
- Absence of any community based AOD support workers

MODELS STAGES
1 = Initial Assessment and Treatment
2 = After Care, Relapse Prevention and Preparation for Independent Living
3 = Exit and Ongoing Support

Town
- No/limited outreach support to work with families and provide follow up care
- VTAC not being used most effectively
- SUS not being utilised for drop in center/day program
- No funded women’s program in Katherine, like StrongBala
- Limited to no crises/short term accom support options

Regionally
- No Formal links from town based services to regional services
- No AOD program at SHS communities
- Limited access at KWHB communities to AOD workers
- No regional AOD related infrastructure
- Lack of regional and remote mandated rehabilitation/treatment options
- Absent/limited regional treatment, support and community integration programs

Appendix 2