

Evaluation of Palmerston Association *Yarning And Parenting Program* for Parents and Children Experiencing Drug and Alcohol Problems



A National Drug
Research Institute
report prepared
for Palmerston
Association



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Report prepared for Palmerston Association

**EVALUATION OF PALMERSTON ASSOCIATION'S *YARNING
AND PARENTING* PROGRAM FOR PARENTS AND CHILDREN
EXPERIENCING DRUG AND ALCOHOL PROBLEMS**

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EXECUTIVE SUMMARY

Introduction

This is the final report on the evaluation of the Palmerston Association *Yarning and Parenting* (YAP) program currently operating in the Mount Barker and Katanning regions. The evaluation aims to inform the development of the program as an alcohol and other drugs intervention strategy working with families with young children.

The terms of reference were to provide:

1. An independent evaluation of the current service delivery model of the YAP program in the Mt Barker and Katanning regions as an alcohol and other drugs (AOD) intervention strategy working with families
2. An assessment of the strengths of the program
3. Development of a framework for best practice around working with vulnerable mothers/carers and their children affected by drug and alcohol use
4. Construction of a demographic profile of YAP clients
5. Development of recommendations/strategies for service improvement and growth in order to deliver best practice services and support to the target client population
6. At the conclusion of the research, NDRI to deliver the findings to the participants of the research in a culturally appropriate manner and format.

Methodology

The research comprised three main elements: a desktop review of academic and ‘grey’ Australian and international literature relating to current and best practice mainstream AOD service delivery for Indigenous and non-Indigenous people. This review was then broadened to include a review of literature relating to best practice family-focused, other mainstream service delivery for marginalised and vulnerable people; face-to-face and telephone interviews with key YAP stakeholders, including clients, staff, and staff at other relevant services; and program information gleaned from documentary material. The limitations of the qualitative element of the research are the small sample size and the unrepresentative nature of the sample. Ethical clearance

for the research was obtained from Curtin University Human Research Ethics Committee (Protocol Approval HR 04/2010), and from the Government of Western Australia Department of Education and Training. All participants were provided with participant information sheets which outlined the aims and objectives of the research, and all signed consent forms.

Evidence of current and best practice of services and support of vulnerable parents and their children affected by drug and alcohol use

An extensive review of the literature on best practice of services and support of marginalised and vulnerable parents and their children affected by AOD use highlighted the scarcity of literature in this area. Whilst there are significant challenges in engaging families and children who are most vulnerable in support programs, a review of best practice principles of parenting and family support services for this population group more generally revealed two key, interrelated, issues: that process issues are as important as program content; and, the increasing recognition and call for AOD services to incorporate child and family focused, or ‘family sensitive practice’ into service delivery.

Development of the processes strongly recommended for services in contact with marginalised and vulnerable families, families affected by AOD use, and for families experiencing multiple problems include interagency partnerships and coordination, and case management. Two areas, in particular, receiving increasing attention to collaborate more closely are those between the AOD sector, on the one hand, and the mental health and child welfare/protection sectors on the other. Case management structures and processes are important in order for services to provide a holistic approach to client care, and to facilitate, and coordinate, access to the range of services the client may need but not otherwise access for a variety of reasons.

Interrelated with both of these issues is the need for AOD services to operate within the wider social context of the AOD users’ lives and to integrate and employ child-focused, family sensitive practice into service delivery. For organisational change in the AOD sector to shift from an individualised to an inclusive approach, there is a

need at the state and national levels for policies and funding structures to regard as core business the needs of children of parents with substance use problems.

YAP project objectives and their achievement: Evaluation findings

We aimed to canvass a range of stakeholder perspectives of the strengths and limitations of the YAP program service delivery model in the interview process. Ultimately, we interviewed: nine program workers; eight YAP clients; and, twelve representatives from other agencies. The program's objectives (Appendix I) provided the framework of themes explored and included stakeholder views and experiences on: alternative pathways for substance users through harm prevention and reduction strategies; case management, treatment and support services; the identification and addressing of gaps in services related to early intervention and support; and increasing clients' awareness and encouraging use of other support services either in-house or externally.

The evaluation findings highlight that YAP's current program model and delivery is congruent with many best practice principles as reported in the literature. Furthermore, the evaluation findings underline that there is no one component of the YAP program model and delivery which can be attributed to its achievement in providing what can be termed, from the limited data, as a valuable service. Rather, this appears to be due to a combination of the multiple levels of prevention, child-focused early identification and intervention, and the various types of support that is provided through the design and delivery of the program. Importantly, program staff were credited for their commitment to serving the best interests of the client population, and for providing a non-judgemental and supportive environment. It is also important to note how program staff, along with other agency representatives, conceptualise the client's participation in the program as a journey towards healing; a journey that takes time, and involves a different process for everyone. Above all, it is the client's interaction with the program that has enabled it to reach the level of success it has so far.

A number of common themes, however, arose from the interviews in terms of areas requiring ongoing development; these revolve, in the main, around organisational

processes and procedures, and limited human and financial resources, and can be summarised as:

- The lack of an independent case management structure and process
- The lack of a relevant internal Child Protection policy and procedure
- The need for a comprehensive child and family focused practice framework
- The lack of formal staff supervision processes
- The need for a best practice framework for working with Indigenous clients
- The need for a coordinated and integrated approach towards clients with comorbidity
- The need for a coordinated and integrated approach towards working with clients experiencing ongoing trauma, grief and loss phenomena
- For internal program monitoring and evaluation to become a core component of operational procedures
- Infrastructure support, such as increased administrative assistance

Recommendations

The recommendations are offered as suggestions for enhancing and strengthening current operations and practices, some of which are dependent upon the YAP program receiving appropriate funding for the important service they offer.

- The YAP program institute an independent case management structure, responsible for the case management initiation, implementation and transition processes and for providing broader support. This would involve a conceptualisation of the model that best suits YAP's clients' needs, and the strengthening of current processes. In addition to evaluating treatment progress from both the client's and worker's perspective, this will contribute towards overall monitoring and evaluation of the service delivery model.
- An internal Child Protection policy to reflect current developments in DCP policy and procedures be developed and support provided to staff in implementation processes. This would necessarily include a formalised

internal supervisory structure in order to ensure that staff are supported in decisions relating to child protection issues.

- A comprehensive child and family focused practice framework be developed, implemented and monitored, and for this to be regarded as core business within the Palmerston/YAP AOD service delivery model. This should include a formal child focused program at both locations, in line with what is currently offered in Mount Barker, and would involve a conceptualisation of the principles underlying child and family focused practice.
- The YAP program institute a more formal supervision process for all staff.
- The development of a best practice framework for working with Indigenous clients.
- The need for a coordinated and integrated approach towards clients with comorbidity. This may involve professional training and development for workers, and/or strong, collaborative partnerships with local mental health services.
- Attention needs to be directed towards integrating contemporary evidence-based practices for the treatment of trauma, grief and loss for clients experiencing these phenomena. This may involve professional training and development for workers, and/or partnerships with clinical counsellors experienced in working within this area.
- For internal program monitoring and evaluation to become a core component of operational procedures. This would involve the development of a formal program logic framework integrating goals and outcomes for both the children and the mother, and be used as a tool for ongoing monitoring and evaluation of the program. Through this process, a more formal framework will be developed around program objectives and outcomes. Client involvement in service planning, delivery and evaluation is recommended.

- YAP staffing levels are reviewed and funded, where necessary, to provide for an internal case management structure, and adequate administrative support.

INTRODUCTION

In March 2010, Palmerston Association contracted the National Drug Research Institute, Curtin University to provide research and evaluation advice and services for the *Yarning and Parenting* (YAP) program currently operating in the Great Southern region of Western Australia.

The terms of reference for this project included the following:

- An independent evaluation of the current service delivery model of the YAP program in the Mt Barker and Katanning regions as an alcohol and other drugs (AOD) intervention strategy working with families
- An assessment of the strengths of the program
- Development of a framework for best practice around working with vulnerable mothers/carers and their children affected by drug and alcohol use
- Construction of a demographic profile of YAP clients
- Development of recommendations/strategies for service improvement and growth in order to deliver best practice services and support to the target client population
- At the conclusion of the research, NDRI to deliver the findings to the participants of the research in a culturally appropriate manner and format – final report due November 2010.

The evaluation included three site visits over a six month period, and consisted of four phases: project negotiation and data identification; formative evaluation including data collection and observation; summative evaluation including data collection and observation; and, analysis, writing and feedback.

The project was conducted by Dr Kate Frances, and supervised by Professor Sherry Sagers.

BACKGROUND

The YAP program provides practical support and counselling for young Indigenous and non-Indigenous mothers/carers and their children experiencing AOD problems,

either themselves or in their families. In addition to their AOD problems, the client group may also be experiencing domestic violence, poverty, child welfare issues, and mental health issues. The majority of YAP clients are young Indigenous women and their children (Non-Government Organisation Treatment Grants Program (NGOTGP), 2010).

The program operates out of two venues; Mount Barker and Katanning. The range of services provided through the program include:

- A group activities program for mothers/carers and children
- Information on harm prevention, drug information, self care, child health, diet and budgeting
- Support and counselling
- A place where parents can feel at ease and get peer support
- Positive parenting skills and encouraging positive engagement with children through craft activities, cooking and play
- Home-based support
- Help with other agencies
- An experienced team of counsellors, a nurse and a child care worker that clients can talk to

([http://www.palmerston.org.au/_webapp_119760/Young_Parents'_Program_\(YAP\)](http://www.palmerston.org.au/_webapp_119760/Young_Parents'_Program_(YAP))).

DEMOGRAPHIC PROFILE OF THE LOWER GREAT SOUTHERN REGION

Table 1 shows a profile of population and age demographics for the Lower Great Southern region (Statistical Division (SD)) overall, and the Shires of Katanning and Plantagenet (Statistical Local Areas, (SLA)) (Mount Barker being the commercial centre of the Shire of Plantagenet). The majority of people in the Lower Great Southern live in the main towns of Albany, Denmark, Katanning and Mount Barker (ABS, 2006).

Table 1 – Population of SD/SLAs across the program sites (ABS Census 2006)

SD/SLA	Community Included	Population (place of usual residence)	% Indigenous Population	% of Indigenous population 0-4 years	% of Indigenous population as youth (15-24 yr)
Lower Great Southern SD	Lower Great Southern	52,593	1,714 (3.25%)	228 (13.3%)	302 (17.6%)
Katanning SLA	Katanning	4,210	370 (8.8%)	63 (17.0%)	59 (15.9%)
Shire of Plantagenet SLA	Mount Barker	4,483	91 (2.0%)	17 (18.7%)	20 (22.0%)

It is well acknowledged that Aboriginal people experience some serious disadvantage across all spectrums of health and wellbeing, and the lack of services in rural and regional areas creates additional difficulties in accessing help, including: issues of confidentiality in small towns, the need to travel in order to access treatment/services, and limited opportunities to access follow-up or ongoing support (SCRGSP, 2009).

The Western Australian Aboriginal Child Health Survey (WAACHS) is the largest and most comprehensive study of Aboriginal child health and development undertaken in Australia. Its main aim is to improve community and scientific understanding of what Aboriginal children and young people need to develop in healthy ways, and provides results across four main areas on 0-17 year olds: physical health; social and emotional wellbeing; educational experiences; and, the role of families and communities in supporting the healthy development of Aboriginal children and young people (Silburn et al., 2006).

From a review of the role of families and communities in supporting the healthy development of Aboriginal children and young people for the regional profile of Narrogin¹, the following are a few of the results reported: 880 (22%) children, and 360 (20%) primary carers were in families that were functioning poorly (which includes financial strain, and children's dietary quality, and overuse of alcohol); 19% of

¹ The Narrogin ATSI Region extends from Dalwallinu in the north to Albany in the south with Ravensthorpe at the most eastern point. Albany, Bunbury and Busselton are major towns in the region.

families experienced 7–14 life stress events (for example, death, incarceration, violence and severe hardship) in the 12 months prior to the survey, similar to the state average of 21%; 10% of houses were identified as being of poor housing quality, significantly lower than total WA of 16%; 9% of dwellings housing Aboriginal children had high household occupancy compared with a significantly higher WA total of 15% (Silburn et al., 2006).

Five key principles evolved from the survey findings to form the basis of recommended actions to improve outcomes for Aboriginal children, families and communities, and include:

- Consult and include Aboriginal people in the leadership, direction, development, implementation and accountability of strategies to improve Indigenous outcomes
- Adjust programme content and delivery to take proper account of the capability profile of the Aboriginal population
- Develop programmes and funding that reflect the Aboriginal population distribution in Western Australia
- Adjust programmes for the regional and cultural diversity of the Aboriginal population
- Test strategy and programme content for its capacity to improve the developmental opportunities to build the capabilities of children and families (Silburn et al., 2006) (WAACHS <http://www.ichr.uwa.edu.au/waachs>).

AUSTRALIAN EARLY DEVELOPMENT INDEX (AEDI)

The AEDI is a nationwide program that looks at young children's health and development as they enter their first year of full-time schooling. Data are collected on each child (no identifying markers are recorded), through a teacher-completed checklist, against the following five key developmental focus areas:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge

These data, which are based on where children live rather than where they go to school, are collated at a population level rather than at an individual child level to focus on *all* children living in a community. AEDI results are then mapped to provide communities across Australia with a picture of where children are on-track or vulnerable within each of the developmental focus areas. These results can then be used to identify, inform and strengthen the types of services, resources and supports that children and their families need in order to give children their best possible start in life (Centre for Community Child Health and Telethon Institute for Child Health Research, 2009).

In 2009, data was collected on 261,203 Australian children (97.5% of the estimated five year old population nationwide), providing the first national census of early childhood development. A culturally-appropriate version of the AEDI to measure Indigenous children's early development status and readiness for school at a community level is being developed and evaluated. (Centre for Community Child Health and Telethon Institute for Child Health Research, 2009).

Importantly, data will not be published on communities with AEDI data: collected on less than 15 children; collected by less than two teachers; which discloses information about all members of a group, for example, where all children in a population are 'developmentally vulnerable' in a particular AEDI domain; and, where AEDI data has been collected on less than 80% of the Australian Bureau of Statistics' Estimated Residential Population of 4 year olds living in that community (AEDI National Support Centre, 2010).

Summary AEDI results for the Shire of Plantagenet

In 2009 the AEDI was completed in Plantagenet for 43 children in their first year of full-time school, 27 of whom live in the Local Community of Mount Barker. Eight schools and eight teachers contributed towards the Plantagenet results. Of these 43 children, six (14%) were Aboriginal and Torres Strait Islander children.

Overall there are 41.5% of children in the Shire of Plantagenet (on whom data were collected) who are developmentally vulnerable on one or more domain/s of the AEDI, and 17.1% who are developmentally vulnerable on two or more domains. In the Local Community of Mount Barker, 38.5% of children are developmentally vulnerable in one or more domain/s, and 15.4% who are developmentally vulnerable in two or more domains. Of note, 34.6% of children in Mount Barker are developmentally vulnerable

in the language and cognitive skills domain compared with a national average score of 9.2% (Centre for Community Child Health and Telethon Institute for Child Health Research, 2010a).

Summary AEDI results for Katanning

The AEDI was completed in the Katanning Community for 89 children in their first year of full-time school, with three schools and four teachers contributing towards the results. Of these 89 children, 16 (18%) were Aboriginal and Torres Strait Islander children.

Overall there are 52.3% of children in Katanning (on whom data were collected) who are developmentally vulnerable on one or more domain/s of the AEDI, and 32.6% who are developmentally vulnerable on two or more domains. Of note: 25.6% of children are developmentally vulnerable in the physical health and wellbeing domain compared to the national average of 9.6%; 25.6% of children are developmentally vulnerable in the social competence domain compared to the national average of 9.2%; and 32.6% are developmentally vulnerable in the language and cognitive skills domain compared with the national average of 9.2% (Centre for Community Child Health and Telethon Institute for Child Health Research, 2010b).

Whilst the AEDI results on their own do not show the context of the communities which may impact on children's development, they do provide a valuable guide for understanding what is working well and what needs to be improved or developed to better support children and their families. In Katanning, for example, the YAP program could pay particular attention to the three domains noted above by integrating a formal child focused program in line with what is currently offered in Mount Barker. This would include closer collaboration and partnerships with other agencies across the child health and development sectors. It would also be beneficial to examine the communities of Mount Barker and Katanning more closely and to identify what the differences in domain scores might reveal about differences in the communities. For example, what social and community supports are available to children and their families? Are there accessible early childhood programs, healthcare services, or family-friendly facilities that may have helped either community?

METHODOLOGY

ETHICAL REQUIREMENTS

The evaluation was guided by the National Health & Medical Research Council's (2003) guidelines for ethical research, and approval for the evaluation was obtained from the Curtin University of Technology's Human Research Ethics Committee (Protocol Approval HR 04/2010). Ethics approval was also obtained from the Government of Western Australia Department of Education and Training authorising us to invite school principals and teachers in the Mount Barker and Katanning areas to participate in the research. All participants were provided with participant information sheets which outlined the aims and objectives of the research, and all signed consent forms. No participants have been identified in the report.

DATA COLLECTION AND SAMPLE

The research comprised three main elements:

- Desktop review of academic and 'grey' Australian and international literature
- Face-to-face and telephone interviews with key YAP stakeholders, including clients, staff, and staff at other relevant services
- Analysis of relevant documentary material

Three site visits were undertaken between March and August 2010 for the qualitative component of the research. The first site visit took place over three days and included formal and informal interviews with YAP and Palmerston staff. Two further site visits took place for a period of five days each visit. The final two visits were organised around the weekly group sessions, involving visits to the Katanning venue on Tuesdays and Mount Barker on Thursdays. This allowed us to document the whole range of activities taking place as well as interactions between staff, children, mothers/carers and other service providers visiting the activities. These observations are a critical component of our assessments of the range and quality of the service being provided to YAP clients, and allowed us to collect baseline data on: types of activities currently in operation; mapping of each activity set-up; number of participants attending each activity; and key stakeholders as identified by YAP staff.

All interviews were semi-structured to allow flexibility for questions to be brought up during the interview. The program's objectives (Appendix I) provided the framework

of themes explored. A total of 30 interviews were conducted with the following key stakeholders, ranging from formal, in-depth explorations lasting more than an hour, to very informal conversations of no more than five or ten minutes:

YAP staff:

- Manager (retired from Palmerston Assoc., in October 2010)
- Aboriginal Elder, Counsellor, Great Southern Community Drug Service Team
- YAP Team Leader
- Project Officer and Support Worker
- Counsellor/Educator
- Childcare worker/art therapist/support worker
- Project Officer/Youth Counsellor
- Administrator
- Childcare worker
- Outreach counsellor

YAP clients:

- Mount Barker: 3
- Katanning: 5

External stakeholders:

- Strong Families (Albany)
- Wanslea Family Services (Albany)
- Plantagenet Medical Group (Mt Barker)
- DCP Foster Care Services (Katanning)
- Katanning Regional Emergency Accommodation Centre
- Great Southern Aboriginal Health Service (Katanning)
- Community Health Social Worker (Katanning)
- Community Justice Services (Katanning)
- Child Development Team (Albany)
- Child Development Team (Katanning)
- Department of Education (Mount Barker)
- Department for Child Protection (Albany)

Documentary material has included program progress reports to funding bodies, Great Southern Community Drug Service Team (GSCDST) weekly group records, Non-Government Organisation Treatment Grants Program (NGOTGP) reports, YAP team minutes of meetings, and other program activity material.

DATA ANALYSIS

Data from the interviews were reviewed and sorted thematically under the program objectives (Appendix I). In addition to this, a review of the literature relating to current and best practice mainstream AOD service delivery for Indigenous and non-Indigenous clients was carried out. This review was then broadened to include a review of literature relating to best practice family-focused, 'other' mainstream service delivery for marginalised and vulnerable people.

LIMITATIONS OF THE RESEARCH

The limitations of the qualitative element of the research are the small sample size and the unrepresentative nature of the sample.

EVIDENCE OF CURRENT AND BEST PRACTICE: SERVICES AND SUPPORT OF VULNERABLE PARENTS AND THEIR CHILDREN AFFECTED BY DRUG AND ALCOHOL USE

INTRODUCTION

Problematic drug use is commonly regarded as being incompatible with effective parenting, and the stigma often associated with AOD use is even greater for mothers. For the children raised in families with AOD misuse there is a high potential for poor developmental outcomes (Barnard, 2005; Dawe et al., 2006). Obtaining accurate national estimates of the number of children living in households with parental AOD misuse, however, is difficult as national surveys that collect data to monitor drug use and drug trends across Australia do not collect information on parental status or child care responsibilities. Furthermore, data from national surveys typically overlook marginalised and disenfranchised minority groups, despite substance misuse being over-represented among these groups (Dawe et al., 2006).

Families with problems associated with AOD misuse are likely to require help across many different areas of their lives, including: controlling their substance use; co-occurring psychological disorders; parenting skills; family discord; external stressors such as housing, education, employment and financial strains; accessing other support systems, and in increasing the social engagement of the parents and their children in society more generally (COAG, 2009; Dawe et al. 2008; Marsh et al., 2007). AOD services working within the traditional treatment paradigm of focusing on drug and alcohol use and the user to the exclusion of the wider social context equates to losses for the clients now and for their children both now and in the future (Dawe et al., 2006; Trifonoff et al., 2010).

A review of the national and international literature on best practice of services and support of marginalised and vulnerable parents and their children affected by AOD use highlighted the scarcity of literature in this area. The search was expanded, therefore, to identify best practice principles of parenting and family support services for this population group more generally. Two key issues emerged from this search: process issues – for example, collaborative working alliances and case management – are as important as program content; and, an increasing recognition and call for AOD

services to incorporate child and family focused, or ‘family sensitive practice’ into their service delivery (Dawe et al., 2006, 2008; Trifonoff et al., 2010).

AOD family-focused service provision

The traditional focus on drug use and the drug user remains the dominant treatment paradigm in AOD services and it is not uncommon for researchers, social workers and other professionals to become overly focused on the extent of the substance misuse, rather than on the impact that it is having on family functioning, relationships within the family and the experience for the child (Forrester, 2004). On the other hand, there are a number of drug and alcohol agencies which claim to deliver family-focused services, but often experience difficulties in delivering such services due to resource constraints and a range of other issues (Gruenert et al., 2004). Others ‘squeeze this in’ wherever and whenever opportunity, time, access and resources allow (Trifonoff et al. 2010, p. v). It is often the case, however, that agencies struggle to manage the substance use problems of their clients, let alone tackle the wider impacts of the AOD use (Gruenert, 2004, p 31).

There are few studies that have evaluated parenting programs that target AOD using parents, as well limited evidence regarding the extent and effectiveness of treatment and intervention approaches to AOD use among Indigenous people (DoHA, 2007; Gray et al., 2000; Teasdale, 2008). Of the few interventions that have been evaluated the following have been noted as promising: home visiting programs with substance misusing parents; intensive interventions with families affected by parental substance misuse; and early intervention to prevent pregnancy in vulnerable women. It is reported that the more effective intervention programs are: ecologically-based; target multiple levels of family functioning; and/or operate within an ‘empowerment of families’ practice philosophy. The potential to benefit both family and child development were important features of the programs (Dawe et al., 2008; Toumbourou et al., 2003).

Mainstream AOD service delivery for Indigenous clients

Case studies have been published on Indigenous specific AOD treatment services judged to be good practice models, but very few published data are available on the acceptability and appropriateness of mainstream AOD services for Indigenous people.

Access by Indigenous people to the appropriate range of health and wellbeing services is affected by ‘discrimination, stigma and disadvantage particularly for problems such as injecting drug use and inhalants’ and for those incarcerated (Ministerial Council on Drug Strategy, 2004a, p. 5). It is also well recognised that Indigenous people face complex circumstances related to financial, cultural and social barriers in accessing mainstream services (Gray et al., 2004; Taylor & Kroll, 2010; Teasdale, 2008).

In order to reduce some of these barriers to accessing services, it is recommended that:

- Mainstream workers need to understand the needs of Aboriginal and Torres Strait Islander people
- Aboriginal and Torres Strait Islander workers need to be able to provide the necessary primary care
- Intervention needs to take account of cultural, spiritual, language and traditional aspects of the community
- People need to be aware of the range of services that are available and to understand how to access them
- Services need to be aware that while the “problems encountered” as a result of alcohol and other drug use by Indigenous and non-Indigenous groups are similar, “the way each addresses those problems may be quite different”
- A service offered to Aboriginal peoples needs to be culturally secure (Ministerial Council on Drug Strategy, 2004a, pp. 1-7).

AOD services working with women

A number of strategies for AOD services working with women have been recommended, including:

- The option of a female counsellor is available
- Counsellors are sensitive in assessment and handling of issues of sexual abuse and domestic violence
- Women are linked to support groups and additional support services
- Where possible, women are enabled to participate in women-only groups
- Programs pay attention to the full range of health, justice and welfare issues that women may be facing

- Treatment services assist with the provision of child care where needed (Marsh et al., 2007, p. 18).

And when working with pregnant women, it is further recommend that:

- Counsellors remain cognisant of the increased levels of shame and stigmatisation that drug using pregnant women suffer
- Counsellors need to facilitate client's engagement with appropriate medical personnel and referral to appropriate antenatal services (Marsh et al., 2007, p. 18).

Mainstream parenting and family support programs for marginalised and vulnerable people – what works?

There are significant challenges in engaging families and children who are most vulnerable in support programs. Such families frequently remain isolated from social and community support and are consequently hard-to-reach. (Centre for Community Child Health, 2010). Three main categories of hard-to-reach families include those who are: under-represented – and include families from marginalised, disadvantaged or socially excluded backgrounds; invisible or overlooked – potentially including families from the above population groups, with their invisibility making them hard to identify in the first place; and service-resistant – families choosing not to engage with services, or are wary of involvement for a multitude of reasons (Carbone et al., 2004; Cortis et al., 2009; Katz et al., 2007).

There are a number of factors, both primary and secondary, which have been identified as preconditions for services successfully engaging marginalised and vulnerable parents. These include:

Primary factors (which suggest that the success of interventions is determined as much by the *way* in which services are delivered as by *what* is delivered) include:

- The quality of relationship between the parent and the service provider
- The establishment of shared decision-making
- Cultural awareness and sensitivity
- Non-stigmatising interventions and settings

- Minimising the practical and structural barriers to accessing services
- Providing crisis help prior to other intervention aims (Barnes, 2003).

Secondary factors include:

- Provision of assertive outreach and support to families not yet connected with other families or services
- Provision of a mix of ‘soft’ (providing service users with a range of accessible, non-stigmatising support services. Such services provide contact points where service users can access support to more specialised, targeted and intensive services) and ‘hard’ entry points to the service system
- Establishment of strong reciprocal links with other relevant services (universal and specialist) (Carbone et al., 2004; Soriano et al., 2008).

For culturally and linguistically diverse (CALD) and Indigenous clients, in particular, free child care services, assistance with transport, use of bilingual workers or interpreters, and the incorporating a meal into the program are key to client engagement and retention (Soriano et al., 2008, p. 3).

Process issues in working with marginalised and vulnerable families

Interagency partnerships and coordination, and case management are both recommended for services in contact with marginalised and vulnerable families, families affected by AOD use, and for families experiencing multiple problems (DAO, 2008; Soriano et al., 2008).

Interagency partnerships and coordination

Cooperation, collaboration and networking between different service providers at the local level are related to positive outcomes for children and their families (Soriano et al., 2008). Two areas receiving increasing attention to collaborate more closely are those between the AOD sector, on the one hand, and the mental health and child welfare/protection sectors on the other.

AOD sector and the mental health sector

Estimates posit that between 50% and 75% of people with a lifetime prevalence of drug problems or dependence also have an ongoing mental health disorder (Roche & Pidd, 2010). Marginalised and vulnerable people do not access mental health services in proportion to their need, compounding the problems for these population groups (Gray et al., 2010). Furthermore, greater impairments in child outcomes might be attributed to the coexistence of parental AOD misuse with parental psychopathology, rather than substance abuse alone (Dawe et al., 2006). AOD treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role, either through improved training opportunities for AOD workers to better address mental health issues, and/or improved liaison with mental health services (Dawe et al., 2006, p. 48).

AOD sector and child welfare/protection sector

Whilst exact figures are unknown, drug and alcohol use is a contributing factor in many families identified by child protection services as requiring intervention (DAO, 2008; Dawe et al., 2008). There is growing awareness, however, of the tension that is generated between the separate and isolated approaches taken toward working with children, on the one hand, and parent with AOD problems on the other. These 'different professional missions', or silo approaches, can have major limitations and unintended negative consequences for the children involved (Taylor & Kroll, 2004; Trifonoff et al., 2010).

For AOD using mothers, the main form of assistance they typically receive is scrutiny of their parenting practices and the subsequent removal of their children (Cousins, 2005; Dawe et al., 2006). Significantly, Indigenous children are under-represented in children's services and over-represented in child protection and juvenile justice services (AIHW, 2008). AOD services are thus encouraged to collaborate with other services in order to broaden the availability of programs to the Aboriginal population (Ministerial Council on Drug Strategy, 2004a). Assessing and responding to AOD problems through: discussion of parental responsibilities and stresses; holistic service provision and the means by which this can be facilitated; and, the promotion and support of the development of child protection policies in AOD agencies are some of the ways towards achieving better outcomes for all involved (DAO, 2008).

Case management

There is a strong argument that all clients, particularly those with multiple and complex needs, accessing AOD services should be case managed in order to provide a holistic approach to client care (Connelly, 2003; Marsh et al., 2007). Whilst the rationale for case management as part of AOD program delivery is strong, there is, however, a degree of ambiguity and confusion in the concept of case management and its application in diverse AOD settings. A number of models of case management are described in the literature, including:

- The broker or generalist model – this is the traditional approach, widely used in the AOD field, derived from social casework. It is an office-focused approach with emphasis on assessing client needs, referral to other agencies, co-ordination of services and monitoring of treatment
- The clinical case management model – here the clinician is responsible for treating the client using interventions such as counselling, psychotherapy and/or pharmacotherapy, and also in providing a case management service similar to that described as the broker model
- The assertive community treatment model – this involves a multi-disciplinary team (e.g. psychiatrist, mental health nurse, social worker, case manager), low client:staff ratios, the services are provided in the clients' homes and workplaces not the clinics, 24 hour coverage, no time limits on services, and all team members providing the services rather than having individual responsibility for particular clients
- The strengths-based model – here the focus is on clients' strengths, seeking to reinforce them and increase client self-determination. Services are provided on a one-to-one basis, generally in the community rather than in the office (McDonald, 2005, p. 9).

Organisational structures for case management in the AOD field tend to fall into three types: a single agency undertakes case management, either as its sole or dominant activity or as part of a suite of helping services including active treatment; informal inter-agency teams are developed to address the needs of particular clients, often on a case-by-case basis; or standing, formal arrangements between agencies are developed with specific funding allocated for the purpose (Siegal, 1998).

All models of case management share the fundamental principles of collaboration, assessment, planning, advocacy and linking clients with necessary services. As case management is a multifaceted process, the case manager draws on a range of skills to promote and maintain a supportive alliance with the client (Connelly et al., 2003).

Professional dangerousness

The process of engaging clients and collaborating to identify the client's strengths and needs is challenging for workers in settings where children are also involved (such as those from drug and alcohol, child protection, mental health or a range of family support services). One of the more consistent messages from, in particular, the child protection and social work sectors is that workers can form allegiances with parents that are not helpful and are potentially quite dangerous for the child in need of protection. Allegiances in this context refers to the concept of 'professional dangerousness' where the worker's emphasis upon preservation of the working relationship with the parent, interferes with the professional's ability to respond protectively to harmful situations for the child (Dale, Davies, Morrison and Waters, 1986). The difficulty for adult-focused drug and alcohol workers to identify the needs of the child is often due to their close working relationship with the parents (Cousins, 2005).

Performance indicators of agency functioning

Performance indicators of agency functioning are as important as client functioning, and should reflect high quality service standards. The quality improvement processes that should be in place at each agency to ensure the development, maintenance, review and revision of clear policies, procedures and practices around:

- Rights and responsibilities – the service recognises clients as health consumers with concomitant rights and responsibilities
- Consumer focused practice – the service encourages consumer participation and considers feedback from consumers on an ongoing basis to inform planning and development of non-discriminatory practice
- Evidence-based practice – the service ensures consumers are well informed of the service options available to them, receive a coordinated and appropriately planned service in accordance with evidence-based practice and clinical/practice governance principles that is negotiated with the individual

and provided by appropriately experienced staff to best meet the consumer's needs

- Staffing, development and support – the service provides adequate and appropriate staffing, development and support for maximum effectiveness of service delivery
- Organisational governance and management – governance and management practices maximise organisational efficiency, transparency, effectiveness and ensure accountability (Wanada, 2005).

Workforce development

Workforce development for the AOD sector (and other sectors including health and child protection) is crucial to assist workers to respond more effectively to clients' multiple and changing needs (DAO, 2008; Roche & Pidd, 2010). Effective workforce development:

... goes beyond just the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development, and worker wellbeing. This broader approach to workforce development involves a wide range of individual, organisational, structural and systemic factors that can impact on the ability of the workforce to effectively and efficiently respond to AOD issues (Roche & Pidd, 2010, p. 2).

Roche and Pidd (2010) provide a comprehensive analysis of the issues impacting on the AOD sector and note among them: leadership and management – which recognises the need for the development of leadership and management skills among the AOD workforce; this will involve leadership development initiatives targeting a broad range of roles requiring leadership skills such as team leaders, supervisors, and managers; infrastructure support, in particular adequate funding levels; the 'demonstrated need' for clinical supervision and mentoring - a substantial proportion of the AOD specialist workforce has limited to no access to clinical supervision and mentoring opportunities (Roche & Pidd, 2010, p.67). Supervision is an essential component of best practice, and it is to the detriment of workers, administrators and ultimately the clients when this is not provided (Connelly, et al., 2003); and worker support – encompassing a

range of factors from supportive management and supervision to sufficient work-related resources (Roche & Pidd, 2010).

In addition to the above, the evaluation of program effectiveness in informing the development of AOD programs is noted as an important workforce development issue. On-going program evaluation is necessary to build on best practice and adapt to changing conditions, and necessarily involves initiatives that develop effective partnerships between research and service delivery agencies (Roche & Pidd, 2010). Barriers to program evaluation include the lack of funding and, for programs with an Indigenous client base, the application of inappropriate evaluation methodologies (Roche & Pidd, 2010; Saggars & Gray, 1998). Saggars and Gray (1998) propose that best practice evaluation must have a pluralistic methodology of quantitative and qualitative data collection. Of note in this context, the ‘diagnosing’ of Indigenous clients based on non-Indigenous criteria have been criticised for minimising the qualitative, holistic perspective often favoured for evaluating Indigenous health programs (IGCD, 2003). Furthermore, consumer involvement in service planning, delivery and evaluation is crucial for quality improvement practice (WANADA, 2005).

AOD POLICY ISSUES: WHERE ARE THE CHILDREN?

There are a number of different state and national policy documents that support the development of a parental drug misuse framework which accounts for the impact of AOD use on children (DAO, 2008, p. 5). In Western Australia, for example, *The Policy Framework for Reducing the Impact of Parental Drug and Alcohol Use on Pregnancy, Newborns and Infants* (2008) identifies a number of principles and strategic priorities for service provision, including situating children as a priority within a family inclusive practice (p. 10). In addition, the Western Australian Drug and Alcohol Strategy 2005-2009 (DAO, 2005) provides the broader context for the development of a framework specifically targeting drug and alcohol users who are pregnant or who have children, and outlines the comprehensive range of strategies that more generally target AOD related issues in WA. The strategy identifies children and young people as a priority group for intervention and highlights the need to develop ‘family focused strategies to assist parents with alcohol and other drug problems to

address their use and strengthen parenting skills, in order to prevent their children entering care' (DAO, 2005., p. 6).

In the national arena, the Australian Government's *Protecting children is everyone's business: National framework for protecting Australia's children 2009-2020* (COAG, 2009) identified parental drug and alcohol abuse as a key risk factor for child abuse and neglect and highlighted scope for improvements in AOD services through a greater focus on 'child and parent-sensitive practice' (COAG, 2009, p. 21). A review of the Australian Government's *National Drug Strategy 2004-2009* reveals that there is no specific reference to the needs of children raised in substance-misusing families, although one strategy objective does state as its aim 'to reduce drug-related harm for individuals, families and communities' (Ministerial Council on Drug Strategy, 2004b, p.5). As this strategy may be viewed as a cooperative venture between the federal government and State/Territory governments and non-government sectors, it raises concerns about the relative importance given to providing services to children affected by parental substance misuse across the political spectrum (Dawe et al., 2006, p. 154).

Importantly, the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 (Ministerial Council on Drug Strategy, 2004a) recommends that programs:

- Collaboratively implement programs to support development of parenting and life skills programs for children and young people (p. 15)
- Improve care and protection of children (p. 25).

Although the AOD field has made significant changes in the way it responds to families affected by AOD use, there is still a major challenge ahead; that of routinely implementing family approaches into service provision (Copello et al., 2005; Dawe et al., 2006). These changes should not be left solely to the treatment agencies: policy makers need to clearly recognise that the evidence suggests a move away from individualistic approaches towards the ones more grounded within people's social context and networks providing for a more socially inclusive provision (Copello, et al., 2005, p. 275). Until family-focused service provision becomes core business in AOD services little is likely to change for the many children living in families with

parental substance misuse (Dawe et al., 2008, p. 1). In other words, until policies include a focus on children and families within the AOD field, organisational change will be difficult to achieve (Dawe et al., 2008, p. 1).

Good practice principles for funding bodies and/or organisations include:

- Regarding as core business the needs of children of those who have substance use problems and providing organisational support for such work to take place
- Treatment models that address many aspects of families' lives, and that are responsive to the needs of families to ensure treatment engagement.
- Interagency practice guidelines that facilitate staff across different agencies working together in a safe, ethical and helpful way (Dawe et al., 2006, p. xii).

YAP PROJECT OBJECTIVES AND THEIR ACHIEVEMENT: EVALUATION FINDINGS

OVERVIEW OF YAP

YAP's origins

The YAP program was borne out of a recognition that young parents with AOD problems, particularly young Indigenous mothers, were not generally accessing health services in the Great Southern region of Western Australia. Thus, in 2004, staff from Palmerston Association's GSCDST began a process of identifying what these young people wanted in an AOD service, and carried out a number of community consultations, including focus group discussions, in the town of Albany, WA. The community consultations were facilitated by a respected Aboriginal Elder with strong links to the local community (and one of Palmerston's GSCDST's longstanding AOD counsellors), and integral to this process was the participation of local Noongar women. Some of the issues raised during these consultations were: difficulties caring for their children, fights with partners, lack of resources, and troubles with the Department for Child Protection and Centrelink.

From these consultations, a program was designed that would provide practical support and evidence-based clinical interventions in a friendly manner to this target group. The program was designed around a weekly playgroup where mothers could bring their children to a safe environment, and that also offered educational and craft activities, and consultation with the nurse and/or counsellor. The aim was for clients to develop peer support networks and spend positive time with their children. In addition, an outreach component was initiated for a counsellor to visit families at home to offer support and general advocacy in relating more positively to government agencies.

Funding was subsequently obtained that allowed a team to set up and run the program. This team consisted of a part-time counsellor, nurse, and childcare worker. Programs were then established in Katanning and Albany, and were supported by Palmerston's GSCDST, including ongoing support and mentoring by the team's Indigenous AOD counsellor (this support continues to this day). Referrals to the program came from the Department of Justice, the Department for Child Protection, Aboriginal Health and

self referrals. Initial challenges included finding suitable venues, lack of equipment for cooking, craft work and so forth and attracting the target group to the weekly sessions.

The YAP program has evolved considerably during these past seven years, but has remained true to the original design of the service (weekly group sessions) and the core objectives. The following provides a detailed description of the YAP service delivery model in 2010.

YAP today

The primary target group of the YAP program is Aboriginal mothers and their pre-school children (0-5 years), where either the mother or other parent/carer has drug and/or alcohol problems. It is understood from staff interviews that both adults and children are considered clients of the program, although children are not formally registered as such. The YAP program operates out of two locations, Mount Barker and Katanning. There are continuities and differences across these two sites in both the specifics and the general in terms of the facilities, resources, and client group. In terms of continuities, both locations offer: a one-day, 4/5 hour women's group/playgroup for mothers/carers and their children; one-on-one counselling (delivered in the client's home, or at the venues); support for clients in accessing other support services; health interventions, BBV/STI testing and education; and, outreach/home visits (taking in Mount Barker, Katanning and Albany regions) (NGOTGP, 2010). The Population Health nurse (currently working three days per week with the GSCDST team through a collaborative interagency agreement (NGOTGP, 2010, p. 7)) attends group sessions alternate weeks for screening, and/or visits clients in the privacy of their home. In addition, guest speakers are invited to both venues to give information sessions on a range of topics.

To facilitate access to the program, pick ups and drop offs are available where needed. Nutritional mid-morning snacks and freshly made lunches are provided and, in Katanning, lunch includes a fresh salad from the venue's vegetable garden. Tea and coffee are available at all times, and clients are encouraged to make themselves at home. Both locations have the clients' art and craft work decorating the walls. Children's toys, books, and art and craft materials are evident. Large tables are

available for art and craft activities doubling up as the dining table, with smaller tables and chairs provided for the children. Large play equipment is available at both venues.

Recruitment of clients

From interviews with staff, it is understood that the process for becoming a YAP client can include: referral from other agency; court mandated to work off community service hours; court mandated to attend AOD counselling; and self-referral. All clients (mothers) are processed through the GSCSDT Albany office, and will undergo an assessment to ascertain the most suitable service provision available from within the GSCDST. Clients registering for the YAP program complete and sign an Episode Registration Form; and A Privacy Statement & Authority to Release/Obtain Information Form.

Mount Barker – the space

The YAP program in Mount Barker operates out of a spacious, well maintained house converted into office space. The building is situated on a large block, with a fenced in grass area in the front, a driveway to the side leading to a tarmac parking area out the back. The interior of the building is divided into multiple rooms, serving as: computer/telephone room; one-on-one counselling/consultation room; staff room; art room doubling up as the lunch room; children's room; and, general gathering space. Visiting service providers can make use of the consulting rooms available. Clients have full use of the building, apart from the staff room, and its facilities and resources. This venue is the central office for YAP and related activities in the region.

Mount Barker - the program

There are aspects of the Mount Barker program which distinguish it from Katanning in important ways, some of which may be circumstantial and others deliberate. Of particular note is the integration of a family/group approach with an early intervention child-centred component. The family component (which is a shared feature of both venues) consists of group activities for mothers and/or their children such as arts and crafts – for example, making jewellery, painting - shared mealtimes, and occasional outings. There is also a strong and regular attendance at the venue by other service providers including Allied and Child Health.

However, it is the early intervention child-centred component which sets this venue apart from Katanning, and is characterised by several important elements:

- The successful partnership between YAP and Wanslea Family Services – an experienced child-care professional, targeting child development and parenting, works with the YAP team and clients three days per week, including: each YAP session; outreach visits one day per week; and, an additional day planning activities/team meetings (monthly) and, more recently, holding cooking classes outside of the YAP session. Child activities and child-focused resources are provided through Wanslea Family Services
- The regular attendance by a range of child development services, for example, speech pathology, hearing, occupational therapy, physiotherapy
- Outreach visits with counsellor and Wanslea child care worker as needed/requested one day per week

Mount Barker – the client/attendance

We were told by YAP staff that the majority of mothers attending YAP in Mount Barker are self-referrals. During our site visits, eight mothers/carers, 12 children, and five staff were in attendance (2nd visit); and six mothers/carers, eight children, and four staff (3rd visit). Visiting agencies (across both visits) included:

- Department for Child Protection (DCP)
- Great Southern Aboriginal Health Service
- Domestic Violence Legal Unit
- Child and Adolescent Mental Health Services
- Police

Katanning – the space

The YAP program in Katanning operates out of a comfortable, single-story house in a residential area. The building is identified by a colourful, hand-crafted ‘Our Place’ mosaic beside the front door (which, we were told was created by the clients giving a sense of ‘ownership’ of the space). The building is situated on a large block, with a colourful fenced in area in the front, a covered concrete area at the back as well as a

large, grassed backyard, and a vegetable garden. The backyard also comprises a sandpit, and a variety of children's play equipment. The interior of the building consists of one very large room, serving multiple purposes – including a seating area, a dining/art and craft area, and a kitchen area - and several smaller rooms used as office/counselling space, baby-changing room, and storage. Clients have full use of the building and its facilities/resources.

Katanning - the program

The Katanning program has a strong group focus, together with an evolving early intervention, child-centred component. Group activities consist of:

- Arts and crafts, shared mealtimes, and occasional outings
- Visits by other service providers including speech pathologist, child health nurse

The early intervention, child-centred component is, as already mentioned, evolving and, during our site visits and subsequent discussions with staff, additional resources are being sought to strengthen this aspect of the program. At present, it is characterised by several elements:

- YAP child care worker (untrained)
- Increasing attendance by a range of child development services, for example, speech pathology, Child Health Nurse
- Outreach visits with counsellor and child care worker as needed/requested one day per week

Katanning – the client/attendance

We were told by staff that the majority of clients in Katanning are either referred by other agencies, or mandated by court to attend for either AOD counselling, or to work off their community service hours. Some clients continue to attend YAP once they have met the terms of their community order (this was the case for two mothers interviewed). During our site visits, seven mothers/carers, nine children (including three babies), and five staff (in addition to one TAFE work experience student) were in attendance (2nd visit); and, nine mothers/carers (two male partners turned up and

were politely asked to leave), 11 children, and six staff (3rd visit). Visiting agencies (across both visits) included:

- Domestic Violence Advocacy Service
- Community Health Social Worker
- Child Development Team
- Great Southern Aboriginal Health Service
- Community Justice Services (CJS)
- StrongFamilies
- Disability Services Commission
- Katanning Regional Emergency Accommodation Centre (KREAC)

The following section addresses the five program objectives. Where objectives draw upon the same or similar data we have, where possible, referenced it only once to avoid repetition. In addition, for ease of reading, the term mother is used to denote mother and/or other carer.

OBJECTIVE 1

Provide alternative pathways for substance users through harm prevention and reduction strategies

Activities

Formal and informal education and information sessions

Outreach counselling/home visits/intensive CfC outreach including child care

Parenting support

Weekly playgroup

Performance indicators

Number and type of presentations and group activities; number of participants attending

Evidence that relevant information regarding harm reduction is made available to all program participants

Number of activities regarding harm reduction strategies

VIEWS OF STAKEHOLDERS

YAP clients

Responses by mothers to the benefits of the weekly activities in relation to harm prevention and reduction strategies were positive overall, and varied between direct reference to reduced substance use to the educational value of the formal and informal information sessions. Several mothers interviewed specifically referred to their previous/current AOD use: one (a YAP client for approximately two years), for example, stated that ‘she stopped doing what she was doing ... drugs ... because of the support here’. Another (client for 18 months) credits her attendance at YAP for her not ‘smoking half as much, nor taking any other drugs’, referring to the both the program and the staff ‘as something really good’. A couple of mothers mentioned they were on methadone programs, with one (recent client) talking of the stigma associated with motherhood/pregnancy and AOD use and the relief she felt at being able to talk about these issues in a non-judgemental and supportive environment:

I sat down with [unnamed] to enrol myself... I'm on a methadone program ... had problems growing up... I find it really hard to talk to people about drugs and it's really important that [unnamed] has experienced drugs and alcohol ... now I'm sharing my pregnancy with everyone else. I'm not being judged here (Interview YAP client, 2010).

Other mothers talked of having developed anger management strategies since attending YAP and the benefits of this in their relationships with their partners and their children, with one mother saying that:

At the beginning it was really good to talk to staff about anger management. No one to talk to in [unnamed], can't trust anyone. Good to talk to [unnamed]. Now my partner coming along to barbeque ... now he's supportive of me coming here (Interview YAP client, 2010).

None of the mothers/carers referred to the term 'counselling' as an aspect of the program; rather, the terms 'support' and 'supportive' were widely used, encompassing both the staff and other mothers:

Staff here supportive ... if I need to talk, they listen and understand (Interview YAP client, 2010).

Workers and other mums very supportive (Interview YAP client, 2010).

Everybody talks to you... people spend time with you – mums and workers (Interview YAP client, 2010).

Workers will pull everyone aside and make an effort to speak to them throughout the YAP day (Interview YAP client, 2010).

From the interviews it was clear that the group format of the program provides the kind of support, in a broad sense, that is of value to the mothers for many of whom 'this is all we have ... other than cooking, cleaning, kids' and gives them the chance to 'leave problems at home when come here'. Another referred to the social aspect as 'relaxing, can have a yarn, catch up'.

For many, formal and informal information sessions provide an important reference point for enhancing their understandings and knowledge of AOD misuse. One client, for example, said that:

I didn't know about alcohol and what it does to the body and all that and with the baby. I do now. It's really opened my eyes ... and sex education, it's good for us (Interview YAP client, 2010).

Another referred to a talk on Hepatitis C and how:

It's really good to learn more about risks ... someone coming in and talking about Hep C ... someone who has it ... really good, really happy with how things are going ... we can talk about drugs and alcohol and relationships at YAP (Interview YAP client, 2010).

This mother suggested that facilitation of discussions by people who have experienced the 'issues' under discussion (for example, drugs and alcohol, domestic violence) would be a useful way of getting the mothers to open up and talk:

Sitting around and talking and being facilitated in a group would be good, to share with everyone. Not just a speaker where you listen and then they go (Interview YAP client, 2010).

One mother, however, said that:

Some of the talk's too high-brow. Need to adjust to the women's level (Interview YAP client, 2010).

YAP project team

There was shared agreement between staff that:

YAP is getting to the core of drug and alcohol prevention, and has the potential to provide pivotal turnaround opportunities for children ... it's about giving power to women in families rather than men. We want the evidence base to show that the emphasis on women and children is where it's at (Interview YAP worker, 2010).

Whilst we were told that initial screening involved recording a client's AOD history, it was stressed that direct, confrontational discussions on AOD misuse was a strategy avoided by staff during weekly group sessions; rather:

We are educators during the weekly sessions. We talk about life skills, address social issues... drug and alcohol issues are generally not addressed directly (Interview YAP worker, 2010).

There was general agreement by program staff that this is an effective and appropriate approach in a group setting where:

The mums can feel the stigma, shame or guilt around injecting drug use, STIs (sexually transmitted infections), BBVs (blood borne viruses) and we need to make sure we don't add to that (Interview YAP worker, 2010).

There was recognition, on the other hand, of the limitations to what some of the counsellors can provide in terms addressing the 'hard stuff':

It would be good for a Clinical Counsellor to come in and do that 'hard stuff' ... whether it's [unnamed - staff member] or not ... we can't always do that and there is a huge need ... grief, trauma, intergenerational trauma is huge (Interview YAP worker, 2010).

Nonetheless, the range of interventions the program is providing include:

All women see the nurse at least once (The nurse's position is funded through the Department of Health and Ageing and, through a collaborative interagency agreement, works three days per week with the GSCDST team in Albany) ... We're trying to get women onto primary health plans. During initial screening we take drug and alcohol history and encourage safer practices around drug and alcohol use (Interview YAP worker, 2010).

We observe the mums and then talk about what we observe; it could be the quality of skin, putting on weight, looking healthier. The women are happy to share with workers. They also report on each other. Family members are known to us, and sometimes come along. Also as drug use increases or decreases, there is a corresponding increase/decrease in children's behaviour so that serves as an observable measure (Interview YAP worker, 2010).

Overall, the provision of a:

Supportive, non-judgemental safe space is an important pathway in and of itself towards harm prevention and reduction for those 4/5 hours per week (Interview YAP worker, 2010).

Staff talked of the strong links they have developed with agencies who visit the weekly sessions to provide both formal and informal information, strategies and clinical practice in relation to harm reduction/minimisation strategies (these have been referenced below), and the importance of involving as many diverse pathways towards addressing this Objective as possible.

The outreach component of the program, which:

... occurs one day per week in Katanning, and one day as needed in Mount Barker usually comes about as a result of something that's come up in the group, for example mum not responding to baby. Or else we've been asked to come and visit (Interview YAP worker, 2010).

was also presented as an opportunity for addressing in private some of the issues which might create feelings of shame and/or guilt - injecting drug use, sexually transmitted infections, blood borne viruses - although there was no reference to this by the clients themselves.

In addition, there are some 'universal requirements', or a list of rules, around attendance at the program, which we were told were developed with the clients, and these include:

Children come first. This needs to be learned by some clients – how to interact with their own children. For those working off their hours, they have to attend and listen to guest speakers. They also have responsibilities within the program, washing up and tidying up. Anybody exhibiting any really bad behaviour – bullying, being confrontational, violence – will be asked to leave. If under the influence, we’ll check their behaviour and assess whether it’s appropriate for them to stay or send them away. It needs to be a safe environment for children ... There is no drug raving on premises, no dealing or sorting out deals on premises. The mums are primarily responsible for their own children and can’t use the sessions as a babysitting or crèche type service (Interview YAP worker, 2010).

External stakeholders/service providers

From the perspective of external stakeholders, expectations as to the scope of the program’s impact in relation to Objective 1 were confined to what was considered reasonable and practicable:

... from a weekly, 4/5 hour group/playgroup activity ... the reduction of AOD use is not a reasonable expectation given the complexities of such usage (Interview external stakeholder, 2010).

Furthermore, several service providers noted how, to their knowledge:

No clients we have in common with YAP have totally stopped misusing and we wouldn’t expect them to. One client ... drugs and alcohol, violence, mental health issues, she’s teetering, she has [x] children. She was referred by the Child Health Nurse, got involved with YAP and since then alcohol and drug consumption are right down. She’s given strong and steady support by individual workers at YAP in parenting skills, drug and alcohol, managing child. They linked her in with mental health. Her pressures might even be bigger now but she’s coping better. That’s the kind of support that YAP provides (Interview external stakeholder, 2010).

One informant, who said that about 90% of YAP clients come through their agency at one time or another, also commented that they:

... can't say how effective YAP are in addressing drug and alcohol issues but girls continue to go every week. They love going to YAP, the interaction with people similar to their situation ... they have hugely stressful lives. Anyway, YAP's approach is harm minimisation, rather than abstinence. If YAP helps to reduce some of the problems, that's enough in itself; it can't be a cure-all (Interview external stakeholder, 2010).

Some of the informants talked of their involvement in harm minimisation educational sessions during the weekly group sessions, either informally with individuals or formally through organised events. Topics included, for example:

I've been to YAP in the past and did a session on FASD (Fetal Alcohol Spectrum Disorders). I got a new client out of that day. A couple of years ago we ran regular sessions there – dental, OT (occupational therapy), series of cooking classes. I think the clients want these services again ... and the dietician used to go. We could return and continue. I also ran a Core of Life one-off session – that's about awareness of pregnancy and child birth for 15-19 year olds before they get pregnant (Interview external stakeholder, 2010).

I go in and talk about parenting and attachment issues in a relaxed way. Many of the mums have PND (post-natal depression) ... disengagement with their own children (Interview external stakeholder, 2010).

All service providers interviewed, apart from one, have visited and/or participated in one or more of the weekly sessions either in Mount Barker and/or Katanning and all commented upon the perceived importance of the group/social aspect of the program - with one referring to the set-up as 'communal parenting'. In line with clients' and staff perspectives, the provision of a safe, non-judgemental space was considered one of the major benefits of the program:

YAP staff are non-evangelical. They don't judge. They know that people are making sense of their lives, and these mums have highly stressful lives. YAP is a reason to get out of bed one day a week ... to know they are not on their own... to know they are receiving general support (Interview external stakeholder, 2010).

Documentary evidence

During the reporting period between January - June of 2010, it was recorded that: harm prevention and reduction strategies were presented to 22 groups (between both venues), with a total of 180 mothers attending these groups; almost 50% of adult clients reported IV drug use; the principal reported drug was alcohol at 30%, followed by cannabis at 25% and amphetamines at 18% (NGOTGP, 2010, p. 6-8).

From a review of the documentary material, the recording of individual client information appears to be limited (more on this in the following section); the following comment provides some explanation for this:

When relating to ... injecting drug use there is the stigma & shame felt by the clients, also the issue of confidentiality when there is such diverse roles and programs within the CDST, ie. a YAP client may also be on a court diversion program that stipulates abstinence. The service has a confidentiality policy (NGOTGP, 2010, p. 7)

Weekly GSCDST group records (completed during/post YAP group sessions) note the numbers in attendance rather than individual names. We understand that individual attendance records are kept for those clients mandated to attend the program through the CJS. It was not possible, therefore, for us to evaluate whether relevant information regarding harm reduction is made available to all program participants.

However, from a review of the group records and other documentary material, harm prevention/reduction strategies – including information regarding safer practices, and reduction of transmissible diseases – are recorded as a core component of program activities and include the following:

- Aboriginal health checks
- Pharmacotherapy consultation and management (it is noted that several clients are on Naltrexone regimes)
- Medication reviews
- Pap smears
- STI/BBV testing
- Discussions/educational sessions on STIs/BBVs
- Referrals to hospital/doctors
- Health advice and education
- Aboriginal Health facilitated Women's Health Business Sessions
- Well Women's Clinic

It is recorded that some of these activities are carried out by the nurse in the privacy of the clients' home during outreach sessions. Reports also note how drug education is a component of both one-on-one counselling sessions – through either the GSCDST's Needle & Syringe Program worker (who regularly attends YAP sessions) or YAP Counsellors/Educators - and more informally through 'table discussions' with topics including alcohol use and pregnancy, utilising the 'decision making matrix' and keeping a drink/drug diary (NGOTGP, 2010, p. 6). Again, we did not have access to documented material relating to these aspects of the program.

OBSERVATIONS

Numbers of clients and types of service providers attending the sessions during our site visits have been recorded previously. No formal group educational/information activities were scheduled during these visits. Observations of the activities demonstrated, however, the informal practice of staff addressing harm prevention and reduction strategies, and to providing overall support:

[Unnamed] mother arrives, and is clearly very upset; she's got tears in her eyes and soon as she starts talking to [unnamed] YAP worker she starts crying. Worker spends time chatting with her, and I hear them talking about

Homeswest and StrongFamilies². Whilst they're chatting, the worker starts peeling vegetables for lunch and the mother prepares salad; she is calmer now and laughing a bit. I go over to see if I can do anything to help and worker introduce us to each other, reminding her who I am and why I'm there. The mother says hello to me and that she would like to talk to me but not today, she's too upset. She told me about her family difficulties, including overcrowding and rowing, and I said that was fine, next time.

Sometime later, [unnamed – from other agency] arrives and sits quietly beside some of the mums, (unnamed mother was one of them). She makes herself a coffee, and then comes back and begins chatting to [unnamed] mother, who starts talking about her problems. They have a calm and quiet conversation about what's going on (for reasons of privacy, I moved away shortly after they began talking). Again the mother appears calmer after this chat, and sits outside with some of her friends having a smoke and a chat.

Towards the end of the session, KREAC arrive with a food parcel – fresh fruit and vegetables; all of the mums choose what they want to take home, and this mum talks about making chips for her children – 'they love their chips'. By now she's cheered up, and at the end of the session while I'm outside waiting for a ride back to Mount Barker, she's joking with her friend and talking about cartoon characters (Field notes, 2010).

During our subsequent visit we were told that:

[Unnamed] is receiving intensive support through StrongFamilies. She's linked in with DCP, Housing, social work and she's got YAP (Interview YAP worker, 2010).

It was observed that, between them, staff were in touch with all mothers at some point during these sessions.

² The StrongFamilies program facilitates interagency coordination of services for families facing multiple difficulties at the same time. For further information see <http://www.community.wa.gov.au/DCP/Resources/Child+Protection/Protection.htm>.

SUMMARY

The availability of staff and other service providers to educate and inform around harm prevention and reduction strategies is generally well regarded. This approach takes many forms, and for some translates into practical advice and information, and for all of the mothers benefits are derived through the overall sense of support they receive through attending the program. Importantly, clients' sense of trust in YAP staff is integral to the success of the program. It is also important to note how program staff, along with other agency representatives, conceptualise the client's participation in the program as a journey towards healing; a journey that takes time, and involves a different process for everyone. Above all, it is the client's interaction with the program that has enabled it to reach the level of success it has so far.

OBJECTIVE 2

Provide case management, treatment and support services by utilising GSCDST nurse, counsellors and child carer

Activities

BBV testing and treatment

Outreach counselling/home visits/intensive CfC outreach including child care

Parenting support

Counselling

Formal and informal advocacy

Measures

Number of groups facilitated in Katanning and Mount Barker

Number of participants attending groups each week

Number of individual counselling sessions provided

Number of shared care arrangements (including which agency)

Number of nurse visits to service locations

Number of children attending group activities

VIEWS OF STAKEHOLDERS

YAP clients

All clients referred to the support they receive through attending the program –by the project staff and/or other mothers – and this has already been referenced under Objective 1.

Whilst not referred to as case management, several of the mothers interviewed referred specifically to the assistance given by YAP staff in linking them in with other services providers:

Access to other services is much better through YAP ... they help you with meetings ... I have my ups and downs, call YAP, they refer me on to other services and help with the meetings. Sometimes I come here crying and leave laughing (Interview YAP client, 2010).

Several of these mothers spoke of YAP staffs' direct involvement in meetings with other service providers, and cited this as one of the reasons for their attendance at the program:

I come to see the workers. I don't mind talking to [unnamed], they get involved with meetings outside. Yeah, they're good, they're good advocates for the mums (Interview YAP client, 2010).

The provision of a child care worker/playgroup was commented upon by all mothers interviewed, and the opportunity:

To play and learn ... meet other kids ... things for fine and gross motor skills (Interview YAP client, 2010).

For kids, it's great to interact with other kids, play, they're not socialising otherwise (Interview YAP client, 2010).

were presented as important aspects of the program.

Knowing that the children are being looked after by staff and/or other mothers was seen by some mothers as allowing them:

Five minutes to myself for once (Interview YAP client, 2010).

A break from the kids... quiet space (Interview YAP client, 2010).

One mother talked of leaving her children at the program so that she could attend meetings with other agencies knowing they would be looked after, although we were told by staff that this is generally not encouraged.

YAP project team

YAP staff felt strongly that case management is an important and integral component of their service provision, with recognition, however, that not all clients need to be case managed and the decision to do so is dependent upon how well individual families are managing overall. Referring clients to the StrongFamilies program (we were told that YAP is the principal referrer to StrongFamilies) removes some of the pressures involved with case management (StrongFamilies implement this process).

However, we were told that it can be challenging for clients to get involved with other agencies:

A lot of the women are agency-phobic. StrongFamilies is very challenging for them. In Katanning, agencies pop in often, have a coffee - gives clients a chance to see that they're not the enemy. There are a number of service providers in Katanning, but in Mount Barker not so many although it's increasing. Mount Barker is a hard town to work in. It has a long history of visiting agencies and not so many based here... also a high turnover of workers within agencies (Interview YAP worker, 2010).

There were a few comments in relation to what makes case management work: for one project worker this was 'interagency collaboration'. Conversely, concerns were raised around a range of issues which impact upon staffs' ability to case manage their client loads effectively. These concerns draw upon the broader but interrelated issues of: lack of internal policies and procedures (and/or lack of support to implement them); and human and financial constraints:

Case management

Case management and supervision are taking a long time to put together. I want that to take off. We need processes in place. We really need to keep on track with outcomes (Interview YAP worker, 2010).

There's a lack of processes and procedures in place to support what we do - risk management, case management, client files. We know that we should be doing them but we don't know how (Interview YAP worker, 2010).

[Unnamed] came and talked to us about strength-based action plans for each client. We don't have action plans at the moment. We also need to develop ways of tracking trauma, incidence of trauma... need to develop incidence form to record chronic DV, for example ... how do we do this? (Interview YAP worker, 2010).

File management

We need processes and procedures on how to maintain files ... the client list is not always current ... who does what administratively? (Interview YAP worker, 2010).

How do we capture as much information on clients as possible across the different (GSCDST) groups, for example YAP and Youth for SIMS³ and other data collection? We need to develop processes ... (Interview YAP worker, 2010).

Supervision

Debriefing and supervision needs to be in place for staff ... at the moment we have non-traditional peer debriefing in car, on drives ... (Interview YAP worker, 2010).

Clinical competencies are assessed within Performance Management done every year with [unnamed] (Interview YAP worker, 2010).

Child protection

Anytime we talk with DCP we're concerned we're breaching their policies ... Any conversations we need to have with them need to go through our Manager first but this is not practicable. We need to re-write our policy (Interview YAP worker, 2010).

We have struggled with credibility with DCP in terms of child-centred focus, children as clients, intervention for children. The core sector of our service is drug and alcohol and we need to know how to position women and children as central within that core sector, including building credibility with other agencies, like DCP (Interview YAP worker, 2010).

³ Security Information Management System

Professional dangerousness

There is a danger of the boundaries being blurred between [staff] being over-involved with clients and identifying what it is they do well and focusing on that (Interview YAP worker, 2010).

I'm afraid of colluding with parents. There are strong trust issues with parents. We're working well with DCP ... if we see bruising on children, witness abuse ... I report to my Supervisor and we make a joint decision about contacting DCP (Interview YAP worker, 2010).

Worker support

There is no up-line management to Corporate ... [Unnamed] is leaving and we really need a strong leader advocating on behalf of YAP ... There is no management structure within the program which is problematic; no formal structure in Mount Barker or Katanning. There is no room professionally for individuals to grow. There is no proper supervision. There is funding for three external supervision sessions a year; supervision very important in quality framework (Interview YAP worker, 2010).

We want a framework on new ways of working with families for the next ten years – collaborative work, how and even if we should be doing that. We need a line management structure that supports what we're doing ... we need support from management (Interview YAP worker, 2010).

Resources

Human and financial resources are lacking. It's often a choice between supporting families and/or writing up reports/observations ... a lot of client information is stored in our heads (Interview YAP worker, 2010).

One problem is the ad-hoc decision making that goes on within the team on a day-to-day basis ... staff member offering to do something for a client, not

communicating that to the rest of team. The main problem is not knowing who is doing what and when. We need someone here in the office 5 days a week for admin support, to answer the phones... We need more resources and more processes to deal with these issues (Interview YAP worker, 2010).

The program's 'rapid growth' was also attributed to some of the issues raised above, with one suggestion that tighter parameters around what exactly the service can and cannot deliver be agreed upon or, in other words:

There is an urgent need for capacity to allow service to grow, or to put parameters around what exactly it is that the service is delivering (Interview YAP worker, 2010).

There was quite a lot of discussion around the issue of maintaining up-to-date client files, with some fear around breaching client confidentiality and/or the potential for files to be subpoenaed. These fears have translated into minimum recording of any form of client information, and interrelated deficiencies around the development and monitoring of individual treatment plans. During the course of the evaluation, however, we were told (and observed) that more stringent guidelines around the management of clients' files, and the development of treatment plans (for children and adults), were being developed.

Advocacy is seen by staff as another important role, and occurs formally and informally. Whilst the above issues were not discussed in the context of advocacy, this role is traditionally one of the case managers and, as such, will be impacted by the same constraints. Advocacy-related activities include the following:

We serve as a voice who knows the client and who has the clients' best interests at heart (Interview YAP worker, 2010).

We advocate to the Court – write reports or give verbal in Court (Interview YAP worker, 2010).

Can go with client to the doctor or to the financial advisor – sometimes it's just a form of support without us having to actually do or say anything on the client's behalf (Interview YAP worker, 2010).

For child protection issues the process is different – here we are advocating more formally, filling in contact feedback sheets, or whatever DCP requires. At present there are two children in care. Approximately 60% of clients have been investigated or contacted by DCP at some point. We are in the process of developing a Memorandum of Understanding between DCP South Metro and Palmerston Albany (Interview YAP worker, 2010).

We do advocacy with other agencies (Interview YAP worker, 2010).

We advocate on behalf of the whole client group to have services, for example advocate with the school for a school bus (Interview YAP worker, 2010).

External stakeholders/service providers

The majority of external stakeholders interviewed talked of the importance of YAP staff having incorporated aspects of a case management approach into their service provision. As one informant commented:

Case management as such doesn't really exist from us... we refer people on and then it's up to them. YAP staff provide the kind of service that we and many others can't provide (Interview external stakeholder, 2010).

Stakeholder comments in relation to YAP staffs' approach to case management/work included:

YAP staff are engaging in good old fashioned case work (Interview external stakeholder, 2010).

[Unnamed] is a case worker, she's more involved with clients than other agencies (Interview external stakeholder, 2010).

[Unnamed] is providing much needed hand-holding, without which individual clients would not be accessing my service ... this is a vital part of YAPs' success (Interview external stakeholder, 2010).

YAP are helping other agencies ... they are lifting the load (Interview external stakeholder, 2010).

One informant situated the success of YAP staffs' case management approach within the context of strong interagency collaboration and cooperation, saying that:

The trust that has developed in the relationship between us and YAP staff is to the point that we can share concerns about shared clients without breaking client confidentiality (Interview external stakeholder, 2010).

Documentary evidence

The documentary material supports YAP workers' awareness of the need to develop clear guidelines around agency processes, including case management. For example, it has been recorded that the YAP program workers:

Have begun work on establishing case management procedures that reflect the particular nature of the clients, ie. Aboriginal women and children. In this regard they are utilising the services of Palmerston's Perth ISI project coordinator who has extensive experience in women and children's AOD service provision (Improved Services Capacity Building Grants Progress Report (ISCBGPR), 2010, p. 3).

YAP case management strategies, it is reported:

... involve complex coordination of services. There is the counselling/ clinical component, the children's services role (allied health and childcare), the activity group component, and interventions from DCP and CJS (justice) and each of these have a specific input into the case management which is managed by the program workers (NGOTGP, 2010, p. 9).

On the issue of integrated treatment plans, an integral component of case management, it has been recorded that:

Their impact will be measured by the degree that there is effective collaborative partnership between services; this collaboration may be based on MOU's and procedures arising out of the MOU. This collaboration is ongoing, needs regular attention and monitoring... The YAP program is now integrating the services of the Child Health Team and the Child Development Team (Health Department) into treatment plans for clients (ISCBGPR, 2010, p. 4).

Although the recording of individual client data is minimal, there is support in the documentary material for the development of individual, strengths-based action plans modelled on the AimHi⁴ resources, and for a ten week trial to be carried out for mothers and their children. It was also on record that there are confusions around registrations of YAP group clients and/or outreach clients/visits, as well as a general confusion around capturing information of individual clients as very little is written down (YAP Team Meeting Minutes, 2010, p. 2).

In relation to child care, documentary material notes how:

Communities for Children funding (through the division of General Practice) has enabled the program to have a child care worker alongside the outreach worker to develop and engage children in activities that enhance child development, also to provide child care for clinical and outreach sessions so they are more effective (NGOTGP, 2010, p. 9).

The following are representative samples of further supports being offered to mothers and their children as lifted from the GSCDST group records (without repeating information previously provided):

⁴ AimHi are a suite of resources developed to explore mental health in remote communities and to find new ways to deliver services (see www.menzies.edu.au for further information).

- [unnamed] child in the group with extremely difficult behaviour became too demanding on workers and mums... the strategy was to take child home to dad... WANSLEA to come in and assist mum with the child as we would prefer both were still able to attend
- ... Relationships Australia spoke on stress and is coming back next term to discuss grief & loss/suicide
- Aboriginal Domestic Violence Legal Service had discussion with mums
- Having [unnamed] focus on the children each week and facilitate activities with them makes a difference in the chaos
- One client having DCP visitation [at YAP] with children

From a review of documentary material, between January-June 2010, 17 YAP sessions were held in Katanning, with 335 clients attending; and, 13 sessions in Mount Barker, with 213 clients attending (it has been reported, however, that due to the manual data collection methods employed for the YAP program, these figures might not be accurate) (Service Summary Report, 2010, p. 1). From what can be ascertained from the records, these figures are combined totals of weekly participation rates, as opposed to numbers of registered clients, as it was also recorded that during this period there were: 98 registered clients, including 64 Aboriginal people; and 32 children under five registered.

In addition, it was reported that 23 individuals engaged in counselling sessions with program staff, and 29 clients received liaison/advocacy support from YAP staff. It was also noted that both the Katanning and Mt Barker groups have been fairly consistent during the reporting period, with several long-term families attending. During this period, the YAP team have supported several women through pregnancy and welcomed 6 new babies (NGOTGP, 2010, p.8).

Observations

Observation of the activities demonstrated staffs' ongoing commitment to the principles of some aspects of case management processes, in particular linking clients in with other agencies, and to overall support:

[Unnamed] YAP worker told me that she's off to pick up a client, and I asked if I could go with her; I thought it would be interesting to observe this aspect of service delivery. On the way to client's house, the worker told me that the mother we're picking up is attending the session today for a supervised visit with her children, who are currently in foster care. She mentioned that YAP are working quite closely with DCP on behalf of the mother, and are trying to provide supports to help her keep her baby who is due in a few months. She told me that the YAP venue provides a supportive environment for these visits, for both the mother and the children. She also explained some of the difficulties the mother and her family are experiencing, some of which are ongoing.

The journey took about twenty minutes, and is quite a distance from the Mount Barker venue (impossible to get to if no car). We arrive at her house, a very neat little place, and she comes out almost immediately. She looks very fit, even though she's six months pregnant! She gets in the car and the worker introduces me, telling her why I'm here. On the way back, the worker asks her how she is, how's the pregnancy going, and general chit-chat. The mother's quite quiet, even subdued.

When we get back to Mount Barker, DCP worker is already here (I'm not sure if she brought the children with her or if they were dropped off by foster carer) and she and the worker leave for a private discussion. Shortly after, the worker comes out and has a quiet word with the mother, who goes with her for a meeting with DCP worker.

After the meeting, the mother comes and sits down, and spends a bit of time with her children. YAP staff trying to engage her in conversation, again chatting to her about upcoming birth of her child and interacting with the children. The child care worker also involves the children in art and craft activities, encouraging them to come and do some painting. As well as this, they're running around and playing with the various toys, although one of them stays near their mother ... The mother leaves before the session ends and gets a lift back home by worker (Field notes, 2010).

SUMMARY

Clients and external stakeholders recognise and appreciate the value in YAP staffs' approach to case management. Staff recognise the constraints inherent in a process which has limited internal agency supports and resources to enable them to strengthen this component of their work. Owing to the limited reporting on individual clients – and the reliance upon anecdotal evidence between clients and/or each other – there is a danger of minimising and/or overlooking client priorities. It was suggested that some parameters around program delivery need to be developed and clearly articulated.

OBJECTIVE 3

To identify and address gaps in services related to early intervention and support for young AOD using parents, children and families

Activities

*Outreach counselling/home visits/intensive CfC outreach including child care
Parenting support
Education and information*

Measures

Number of outreach counselling contacts

VIEWS OF STAKEHOLDERS

YAP clients

Whilst none of the mothers referred to the support they receive for their children in terms of early intervention, the majority recognised that the program is providing an important opportunity that was characterised as being unavailable or inaccessible elsewhere. For some, the issue of access was related to transport:

There's nothing going on where I live ... couldn't come here if I didn't get picked up (Interview YAP client, 2010).

Transport really good, it really helps (Interview YAP client, 2010).

[Unnamed] picks me up; I couldn't come otherwise (Interview YAP client, 2010).

For others, it was a question of 'one stop shopping':

Helped my kids, my boy got help with his anger. [Unnamed] spoke to him... helped in learning, toy-time, story-time. I brought all my kids here. It's good it's all here (Interview YAP client, 2010).

Workers really helpful. There are different people coming in – agencies. Speech therapist and OT (occupational therapist). For the first time I've had confirmation from the speech therapist that [unnamed] is probably autistic,

mildly. I feel relieved to finally have a diagnosis. It's good they come here. There's nothing where I live (Interview YAP client, 2010).

For themselves, some mothers spoke of specific interventions:

I got my teeth done here. That was before. A dentist again would be good. Would like to see more of that (Interview YAP client, 2010).

Whilst another said how 'before YAP' she:

Felt a lot of anger ... now don't smoke half as much nor take any other drugs. Was fighting with my ex ... was worried about what could happen if I didn't stop all that stuff. Now I'm bouncing back. I was diagnosed with PND (Post Natal Depression), was on anti-depressants ... was told my kids could be taken from me (Interview YAP client, 2010).

While this mother didn't talk specifically of the lack of services/accessibility of services in her area, she did say that initially 'I didn't want to come [to YAP] but [unnamed] encouraged me', going on to say that:

Now I've Wanslea who've helped heaps with kids ... StrongFamilies – I've got Centrelink, Homeswest, Family Violence ... now I've got kids and YAP. Before I had nothing, now something really good. I'm starting a TAFE course in Certificate II, Business. [Unnamed] has help with that. When I finish I want to teach Aboriginal kids to do homework ... through TAFE and Wanslea. I also want to be advocate for mums here at YAP (Interview YAP client, 2010).

During our final site visit we were told that this mother had started her TAFE course, and was doing one day per week work experience at the Mount Barker site providing general administrative support, and answering the telephone.

When asked about the provision of an Aboriginal support worker at the weekly sessions, some of the mothers said that:

No, I don't think so, I don't want an Aboriginal worker here. They might interfere... know too much. Everybody knows everybody else, like in [unnamed] (Interview YAP client, 2010).

No, not really. Leave all that behind here (Interview YAP client, 2010).

Haven't thought about it. Doesn't matter; I like the workers here (Interview YAP client, 2010).

YAP staff

Staff explained the motivation behind the development of YAP service provision:

We identified a lack of services directed towards women and children, and YAP grew out of this. The venues are really important aspects of service provision ... We're interested in developing clients' and communities' space within the service response (Interview YAP worker, 2010).

We aim to provide a holistic, needs-based model targeted at vulnerable and disadvantaged mothers and their children. There are a number of service providers in Katanning, but in Mount Barker not so many although it's increasing. Mount Barker is a hard town to work in. It has a long history of visiting agencies and not so many based here... also a high turnover of workers within agencies (Interview YAP worker, 2010).

This lack of local services was recognised as situating YAP in an important position with regard to the client group's access in, and participation of, appropriate service provision in that region. There was also a lot of discussion and concern around the cultural appropriateness of the service delivery model for Indigenous clients, with staff asking for recommendations on how to ensure that they are operating within a best practice framework for the client group (the majority of whom are Indigenous).

YAP staff talked of the ongoing process of attempting to fill the gaps in early intervention and support for both the mothers and the children and cited, in particular, gaps in:

Child health

No funding for mainstream child health apart from one day per week per region ... no follow up from midwife although new rules coming in – three home visits and seven home visits for Aboriginal children before school (Interview YAP worker, 2010).

Early education

In Katanning 52% on AEDI scored below average in one or more area. 32% in two or more areas (Interview YAP worker, 2010).

All child development services

Ears, speech, eyes etc (Interview YAP worker, 2010).

Early intervention, including mental health and associated drug and alcohol misuse

Psych support required. Getting to Albany too hard for many. YAP worked with the Division of General Practice to get a psych working with the clients but the psych was also working with CJS so saw a conflict of interest and cancelled her involvement. Unless they travel to Albany they have no access to such services ... No one in Mount Barker working as a psych, so to see a psych you have to offend quite badly ... No one has done any analysis of addiction to prescription meds (Interview YAP worker, 2010).

Department for Child Protection Intake Team

YAP have tried sharing training with DCP but it's not really going anywhere at the moment. We do have good interpersonal relationships but it's the policy/procedural/systemic issues that are problematic rather than personalities. We feel that Palmerston is growing credibility as providers of children's services (Interview YAP worker, 2010).

We were told, and observed, how some of these gaps are being filled by the partnerships and interagency collaborations that the team are committed to

developing. One example of effective early intervention and supports is that made possible through:

... the strong relationship between Wanslea and YAP in Mount Barker. The clients' multiple needs are being addressed through the program and the outreach/home visit component (Interview YAP worker, 2010).

We were told that owing to this strong partnership:

Individual children's developmental milestones ranging from toilet training, speech and hearing delays/impairments... are being identified and responded to as quickly as possible either at the weekly group session or through the outreach visits (Interview YAP worker, 2010).

Other strong partnerships mentioned include: Allied Health; Population Health; Division of General Practice (who fund the program's intensive outreach services under the *Communities for Children* program). We were also told that staff represent YAP on a number of committees including:

- *Communities for Children* Stakeholders Committee
- Mental Health Reference Advisory Group
- Our Place (Katanning venue) Stakeholders Group
- Domestic Violence Reference Group (Katanning)
- StrongFamilies Reference Group (based in Albany but serving the whole region including Katanning)
- Aboriginal Health Advisory Group
- Department for Child Protection Group

Some of the gaps in local service provision are proving to be an ongoing source of frustration: for example, all staff recognised that:

The majority of YAP clients have ongoing grief, trauma and associated mental health issues. Targeted counselling is beyond our expertise. We're aware that

this need is being left untreated through lack of appropriate service provision overall (Interview YAP worker, 2010).

During the last site visit, staff talked about a recent meeting held between a range of service providers servicing Mount Barker (and surrounding regions) to see how they could all work collaboratively to address the gaps in service provision. A further meeting was talked of being scheduled.

External stakeholders/service providers

External stakeholders variously described YAP service provision as:

Child-centred, family focused (Interview external stakeholder, 2010).

A targeted child development/parenting program (Interview external stakeholder, 2010).

An early intervention with children (Interview external stakeholder, 2010).

Others, in particular those who had limited contact with YAP and/or the clients, know of the service as a ‘playgroup’, as a ‘women’s group’, and as having a ‘child care expert’.

One service provider referred to ‘YAP [as] more holistic than most other agencies’. Another was complimentary about the way in which YAP staff target specific needs of individual families, noting how:

Some mothers are comfortable enough to ask about specific parenting/child development issues which can be the basis for more intensive support (Interview external stakeholder, 2010).

Another listed what they consider YAP do best:

YAP support women – finances, housing, AOD issues, and overall community support ... all levels of support (Interview external stakeholder, 2010).

Preparing children attending YAP for school was also raised as:

being really good ... exposure to books, fruit, taking instructions, sitting and looking at books (Interview external stakeholder, 2010).

YAP was also attributed to contributing to the school readiness of two children in particular - who were referred to as 'great' - compared to some other children of the same age. The early intervention of the speech pathologist, in particular, was noted as one of the obvious benefits derived from the children's attendance at YAP, although this was not contextualised within the range of other supports the children may be experiencing.

As a benefit to children specifically, attendance at YAP was regarded by one stakeholder as providing them with 'visibility', in the sense that:

Early intervention is not happening here in Albany ... those kids would be invisible here. YAP provides visibility from child health and development to child protection (Interview external stakeholder, 2010).

It was also suggested that one area where quantifiable change can occur is in the area of early childhood development and for:

The program to continue to focus on doing the things for children that are making a difference, and they're doing that really well (Interview external stakeholder, 2010).

When asked about the inclusion of an Aboriginal support worker in the program's service delivery model, external stakeholders were generally in agreement that this would be appropriate. This was qualified, however, in the context of:

It's a question of building the capacity of an Indigenous workforce/worker, which is a two-way relationship between Indigenous and non-Indigenous ... A huge issue for Indigenous clients is the guarantee of privacy. I'm a neutral

facilitator; I think for me, being non-Noongar, is an advantage (Interview external stakeholder, 2010).

I would like to see a Noongar worker at YAP, but it doesn't stop them from going, not having one (Interview external stakeholder, 2010).

Yes on principle; requires trust both ways. Noongar workers would need a career pathway. Given what I know of Indigenous clients here and [unnamed] more important is that workers have a good understanding and practice, unconditional cultural regard (Interview external stakeholder, 2010).

Documentary evidence

From a review of documentary material, early intervention and support for young AOD using parents, children and families is being addressed in different ways. For example, due to the:

Increased focus on the physical, mental and developmental health of young Indigenous, (under 5) clients, the YAP program is increasingly integrating Allied Health and Indigenous Health workers into its activities (ISCBGPR, 2010, p. 14)

It has also been noted how 'provision of these services works best when the mother and child are attending together, i.e. at YAP playgroups' (ISCBGPR, 2010, p. 14).

During the reporting period January-June 2010, the introduction of child health checks - for example, ear, nose and throat - have been noted. Furthermore, to assist children reaching normal developmental milestones:

The child development team have been attending groups to facilitate education and one-on-one service delivery focussed on bringing children up to age appropriate level (hearing, speech therapy, OT, physio) (NGOTGP, 2010, p. 11).

Importantly, Aboriginal health workers are also attending the program, with this integrated service provision being noted as not only addressing practical issues but serving to develop the mental wellness of the mother (ISCBGPR, 2010, p. 14).

In addition, outreach service is reported as occurring weekly, with between five and ten visits made every week (it was unclear if this relates to both and/or either location). Outreach work relating to family functioning, attachment issues and child development issues involves a YAP worker partnering with a Wanslea Family Services worker (NGOTGP, 2010, p. 10).

Observations

One of the most striking components of the program in Mount Barker is the early intervention work occurring with and for children, not least through the on-site availability of a professional and experienced child care worker:

When [unnamed] YAP worker and I arrive at the Mount Barker venue, other workers and some mothers and children already there. Lunch is being prepared in the kitchen, and fresh vegetables and dips are available for mid-morning snack; plenty of takers. Children's music is playing, some children running around and others sitting and colouring in, mums either sitting with their children or in the reception area drinking coffee and chatting; overall a relaxed atmosphere. Wanslea Family Services child care worker sitting with the children, and engaging with them and their mums.

As I'm sitting there observing what's going on, one little boy comes up to me and asks me if I'm [unnamed] speech pathologist; I tell him no, but that I'm Kate and I'm visiting for the day. He starts saying a lot of words beginning with (hard) c; cake, cup, his name which begins with this sound, etc. Worker tells me that he's really proud because he's been having a lot of speech therapy sessions, and his speech is improving all the time. Shortly after this, worker tells us that the speech therapist can't come today, which is a shame as I'd arranged to meet with her. Worker also comments that little boy will be disappointed as he really likes her; he looks disappointed when she tells him. During the three interviews I have with mothers throughout the course of the

day, all of them mention the speech therapist and tell me how 'really good' she is; one says '[unnamed] is the best'.

In between this and lunch I have an interview with one of the mothers, so I don't observe what's going on, although I notice a woman arrive who I'm told is from the Domestic Violence Legal Service here to see one of the mothers. Lunch is a calm affair, with the children sitting nicely at a separate table from the adults. Some mothers are eating their lunch in another room while others, together with and the YAP and Wanslea child care workers, sit with the children. Lunch is chicken and cheese rolls, and a cup of water. Before eating, Wanslea worker encourages children to say 'thank you for my lunch'. Supervision of eating, sitting and drinking is good, and there's a lot of general discussion among the mums and workers. When everyone has finished eating we all take our plates into the kitchen and wash them up; mums take their children's.

After lunch Wanslea worker puts on a puppet show. I see her setting it up and we have a chat about it; she explains it's a play-based, social learning program for children. Due to interviews, I don't get to see the show although I do see some of the children gathering around in anticipation. The Wanslea worker was talked about a lot in one of the interviews, in particular for 'making me feel important' and as 'a child care expert who has helped heaps with the kids'. This mother also talked of the 'things getting done since YAP's moved into new building ... now health nurse every two weeks, speech pathologist, dentist ... all really good' although I didn't get to observe this as none of these agencies arrived during this visit (Field notes, 2010).

SUMMARY

It is clear from the interviews that YAP clients value the early intervention services provided through the program for their children. In addition, external stakeholders are acknowledging the provision of children's services as a central component of service delivery.

OBJECTIVE 4

To increase clients' awareness and encourage use of other support services; invite other support services to attend group activities

Activities

Formal and informal education and information

Measures

Number of and type of visits to group program by other agencies

Number and description of agencies involved in YAP program

VIEWS OF STAKEHOLDERS

There is an overlap between this objective and the previous three; to avoid repetition this section is necessarily short.

YAP clients

Some of the mothers expressly referred to YAP staffs' facilitation of access to other service providers as one of their motivations for attending YAP. Services specifically referred to included StrongFamilies (which will have at least two other agencies' involvement). Another strong motivation for clients was the value derived from guest speakers/other service providers attending the YAP weekly sessions, with the suggestion from mothers in Katanning that they could benefit from more regular visits. In particular, suggestions ranged from access to dental and health services and 1-2-3 Magic⁵. Importantly, some of the mothers referred to their access of some services as only possible through those agencies' attendance at the YAP sessions, specifically Allied Child Health, Strong Families, and Domestic Violence Advocacy Services.

Another mother talked of her experiences of domestic violence, and how since coming to YAP:

I've been here since 2005, was referred to the service. I've had a couple of breaks in between when I think I don't need support but I always come back. I've come a long, long way ... Was in DV (domestic violence) with my partner

⁵ 1-2-3 Magic is a parenting program providing solutions for dealing with difficult behaviours in toddlers, children and teens. For further information see www.parentmagic.com

... both went to counselling ... me here with YAP and Domestic Violence, my partner somewhere else ... now moving back in together. I've learned a lot. I've tried to get [unnamed] to come but she won't cos she has problems of her own. [Unnamed worker] would call my mum if she noticed anything wrong with me (Interview YAP client, 2010).

One mother, on the other hand, referred to too much agency presence during the weekly sessions:

When too many agencies at once it's not good ... perhaps one week on, one week off (Interview YAP client, 2010).

YAP staff

Whilst all staff interviewed agreed that an important aspect of YAP service provision is in their ability to facilitate access for clients to a range of service providers, they also mentioned how the sheer volume of external agency interest in meeting with Mount Barker clients during program activities is hindering rather than helping clients:

YAP is for the women, it's their space ... too many agencies coming in to Mount Barker ... it's disruptive ... inappropriate. YAP is seen as being able to provide access to clients by service providers who wouldn't normally have access to the mums. We're limiting it to alternate weeks (Interview YAP worker, 2010).

Nonetheless, staff were encouraged by several mothers following up from referrals they organised with the speech therapist (in Katanning) to have children treated with grommets for blocked hearing.

Examples of other supports being provided to clients during particular periods of need include:

If client presents and needs food we will either refer them to the food bank in Albany, give them food from the cupboards, or will shop for food for a couple

of days and give it to them. One of our major aims is addressing inequalities... we would then refer these clients onto StrongFamilies (Interview YAP worker, 2010).

External stakeholders/service providers

As previously mentioned, the majority of service providers interviewed have visited, or regularly visit, YAP during weekly group sessions. Staff and service providers alike referred to agencies 'dropping' in (one service provider calling the venue 'a drop in centre') during group sessions as one way in which to allay the fears of clients, many of whom were referred to as 'agency-phobic'. As one service provider said:

There is an element of shame in some mothers attending mainstream child development services. Coming here, it's like they're not being good parents and that's one of the difficulties in providing supports from here. Being able to access us through YAP has enabled a softer entry into our services (Interview external stakeholder, 2010).

Another, who said they regularly 'drop in' at YAP, noted that:

Keeping up the connection with the mothers and their children is an important aspect of my job, and is as important as being available for the mothers (Interview external stakeholder, 2010).

When asked if they refer clients to YAP, one informant responded 'no...don't hand hold... so, not really my job'. Another said that whilst they do not, the majority of their clients (8 in total) go to YAP anyway, whilst another said that referrals work both ways between YAP and their service. Another was more proactive:

Any woman client with children coming to my attention ... I will automatically refer them to YAP for the overall support I know is provided by YAP staff (Interview external stakeholder, 2010).

There was also acknowledgment by one stakeholder that YAP's Indigenous clients would not visit their service at all if YAP staff did not accompany the client to their

appointment, pointing out that Indigenous clients would be receiving ‘no preventative care’ if not for YAP.

A further point made of the value in agencies attending YAP was in relation to external expertise being in a position to ‘upskill’ staff⁶ on aspects of, for example:

Child development ... brain development ... how to make a difference with the development of little ones. We can provide information on assessments of kids that can be promoted, provided by staff (Interview external stakeholder, 2010).

Observations

During site visits, we observed staff from other agencies attending the weekly group sessions (these have been listed elsewhere). In Katanning, there was a distinct feel of agencies ‘dropping in’ as been mentioned during interviews:

Workers and I arrive in Katanning at about 11am. Other workers and some mothers and children already here; it seems very busy with seven mothers, nine children (including three babies), and eight YAP workers/others (including a TAFE work experience student, one workers’ daughter, [unnamed] who picks up and drops off some mothers, and me). Some of the mothers are sitting down having a coffee and a chat, others are chatting with workers, and others are by the kitchen area making coffee/tea and chatting. One worker is preparing lunch, and another is preparing fruit, vegetables and dips for mid-morning snacks. YAP child care worker and another worker are preparing some arts and crafts for the mothers and the children (the same activities). The student is sitting with some children, and they’re playing with toys.

I start chatting to [unnamed] mother, and worker introduces me; I ask her if she would be interested in chatting with me and she agrees. We have a twenty minute interview before we get interrupted. A man and woman arrive, and I’m told they are from Domestic Violence Advocacy Services. Worker chatting with

⁶ See Appendix II for staff training and development

them, and soon after the woman goes into the counselling room with a client. The man seems at a loose end. I start chatting with another mother, who has recently had her third baby, and after I explain why I'm there we go outside for an interview. Her friend joins us and we spend about 45 minutes together. When we go back inside, someone from CJS has arrived and is chatting with worker. He soon leaves. By this time lunch is served and we either sit in the comfortable chairs, or at the table. Lunch is pumpkin soup, salad and bread. Some mothers are helping their children eat, but I observe that overall there is little interaction between mothers and children apart from when the children are crying or need other help.

After lunch, I have another two interviews outside lasting about one hour and twenty minutes in total. During this time, some children playing outside on swings and bikes and generally running around having a good time. There are a couple of mothers sitting outside having a smoke and chatting, and one paying close attention to her child on a bike. Overall, the children are free to come and go with little focused attention on what they are doing, or in playing with them. I notice overall that the children have no structured routine (and after having observed the Mount Barker activity later on in the week, I realise that an important distinction between the two venues is the strong child focused component integrated into the program in Mount Barker. This is largely due to the on-site availability of a professional and experienced child care worker in Mount Barker). When we've finished with the interviews, I go back inside and notice a woman sitting chatting quietly with some of the mothers. I'm told she's the social workers; she soon starts a private conversation with one mother who is quite distressed today.

Towards the end of the session, many of us start clearing up. In the meantime a man comes in carrying a box of fresh fruit and vegetables. After a quick hello, he drops them off and leaves; he's from KREAC and makes deliveries to YAP from time to time (Field notes, 2010).

SUMMARY

There is obviously a great deal of interest from program staff, clients and other agencies in accessing YAP clients through the program. In Mount Barker, this has been become problematic and/or inappropriate, and visits are being restricted to alternate weeks. In Katanning no complaints were made about the 'open door' or 'drop in' (informal) policy. A balance between accessibility, on the one hand, and client safety and security, on the other, needs to be weighed and managed.

OBJECTIVE 5

To evaluate YAP to ensure the outcomes are achieved

Activities

Administer client surveys
Conduct focus group sessions
Gather information for reports
Record information

Measures

Reports completed and data provided to DoHA on time and as required
Reports to contain analysis of data, results of surveys, report on focus group, report on client outcomes

VIEWS OF STAKEHOLDERS

Whilst we have some documentation relating to client surveys, we thought this section would be usefully served as a space for us to inventory the most salient points for YAP program enhancement as suggested by stakeholders. Some of the issues have been noted previously, others are considered worthy of note in their own right.

YAP clients

All mothers interviewed made suggests of how the overall service provision could be enhanced and/or how things could be done differently. Some of the following are attributable to one mother's suggestion, others have been made (or along the same lines of) by two or more mothers.

Katanning

Fewer men:

Don't like men around all the time. Not so good. Want this to be woman's space
(Interview YAP client, 2010).

More 'adult-like' activities:

Need more things to do for mums, more crafty type stuff instead of colouring in ... kids get enough to do but we could make cushion covers, jewellery, necklaces... nothing like colouring in. [Unnamed] used to come, we'd do weaving, making bags ... every week something different (Interview YAP client, 2010).

More regular attendance by other agencies:

Dentist ... health screening ... would like more of this (Interview YAP client, 2010).

An additional day per week:

Would like to come twice a week (Interview YAP client, 2010).

And, please:

More meat, no more pumpkin soup! (Interview YAP client, 2010).

Mount Barker

Too many agencies attending too often:

When too many agencies at once it's not good ... perhaps one week on, one week off (Interview YAP client, 2010).

More opportunities for facilitated group discussions:

Sitting around and talking and being facilitated in a group would be good, to share with everyone. Not just a speaker where you listen and then they go (Interview YAP client, 2010).

YAP staff

During both individual and group discussions with staff, and attendance at a staff meeting, the following issues were raised as in need of development and support:

Case management guidelines, including

- File management
- Treatment plans for mothers and children and planning around individual families

Risk management processes and procedures, including:

- Occupational health and safety
- Personal safety

Child protection issues, including:

- Updating child protection policies and procedures
- Working with children checks
- Mandatory reporting
- Avoiding ‘professional dangerousness’

In addition: the development of a child and family focused framework; supervision; attention to addressing issues of trauma, grief and loss; framework for working with Indigenous clients; a more efficient line management structure; and, staffing issues and infrastructure support generally, were also discussed.

External stakeholders/service providers

Perspectives for service enhancement provided by external stakeholders include:

Issues of sustainability for both the staff and the program, including:

- Workforce development: training and development; professional supervision; and line management direction and support

More targeted staff and hiring of people for specific role with specific skills, including:

- Culturally appropriate grief and trauma counselling

‘Buying in’ external expertise, including:

- child development expertise
- professional clinical counselling

In addition, employing and building the capacity of an Aboriginal Support Officer was recommended.

Documentary material

YAP clients are invited to complete a six monthly participants’ feedback survey (unidentified), data from which are correlated to provide an overview of client satisfaction with service delivery. It was reported that in the reporting period to June

2010, client satisfaction questionnaires were not completed, although: ‘there has been a significant amount of client consultation both informally and in client interviews which were conducted as part of the ISI project’ (NGOTGP, 2010, p. 12).

SUMMARY

Staff and external stakeholders have identified a number of organisational and operational issues requiring attention in order to strengthen the current service delivery model of the YAP program. For clients, their full involvement in service planning, delivery and evaluation requires that their views are taken into account and acted upon, where possible.

DISCUSSION AND RECOMMENDATIONS

In this report we have tried to include as much relevant data as we can in order to provide a rich account of the overall YAP service delivery model, and its perceived benefits and limitations. The evaluation findings highlight that there is no one component of the YAP program model which can be attributed to its achievement in providing what can be termed, from the limited data, as a valuable service. Rather, this appears to be due to a combination of the multiple levels of prevention, child-focused early identification and intervention, and the various types of support that is provided through the design and delivery of the program. Importantly, program staff were credited for their commitment to providing as holistic a service as possible, and for providing a non-judgemental and supportive environment. It is also important to note how program staff, along with other agency representatives, conceptualise the client's participation in the program as a journey towards healing; a journey that takes time, and involves a different process for everyone. Above all, it is the client's interaction with the program that has enabled it to reach the level of success it has so far.

The service delivery model is to be commended for being, in principle, in line with best practice principles in working with marginalised and vulnerable families as reported in the literature. This is particularly pertinent for the AOD sector where, for various reasons, the wider social context of AOD users' lives - especially their children - is often left unattended (Dawe et al., 2006). Notably, the Mount Barker venue is reflecting a strong child focused component that children and families in Katanning would benefit from if the same service delivery model were formalised into the program at that location.

These same processes, however, require ongoing development for both the program and the service delivery model to develop into a robust, transferable and sustainable model over the longer term. In summary, many of the issues raised below are not criticisms of the service *per se*, but comments about the ways in which the service is compromised by organisational processes and procedures, and limited human and financial resources.

CASE MANAGEMENT

The central goal of case management is to ensure that the client has access to the services and resources that he/she needs, when they are needed. This involves coordinating the range of services in which the client may participate with a view to overcoming the gaps and obstacles that can occur between health and social services delivered by different providers, and regular monitoring of case management activities and outcomes (Connelly et al., 2003; Marsh, et al., 2007).

Referral to and facilitation of clients' engagement with other agencies is one aspect of the internal case management system instituted by the YAP program that has been recognised as not only working well but as a necessary and often neglected aspect of service delivery generally. It would appear, however, that this process is constrained by the absence of a clear conceptualisation of the model that best suits YAP's clients' needs. This seems to be a product of several factors: lack of internal agency processes; the organisational structure of staff roles and responsibilities; and, lack of human and financial resources (addressed further on).

Staff roles and responsibilities

The YAP program is structured in such a way that all program workers are working with and for all clients. No one person is designated to the role of 'case manager' or 'counsellor' and as such all roles and responsibilities are fluid, responding to client needs as and when they arise. We recognise that this is a feature of: the grass-roots approach to the development of the program; and, the group setting component and the interplay between this and the relationships that form over time between clients and all/individual workers. This often translates, however, into multiple and overlapping levels of communication between different staff members and clients. Apart from where that information is shared during debriefings, meetings and so on, there is no process in place which allocates one individual responsibility for regular monitoring of case management activities and outcomes. It is important to note that the case management process is not intended to replace the activities of the counsellors and other workers; rather it represents a central point of coordination for the range of other services involved (Connelly et al., 2003).

File management

Another important issue impacting upon the YAP program's capacity to provide an effective case management process involves difficulties in maintaining up-to-date client files. This impacts considerably upon the case manager's (or person assuming that role) capacity to develop individual treatment plans, assessment of whether treatment goals are being met, and risk assessments, all of which are integral components of both the case management process and, importantly, best practice principles (Connelly et al., 2003).

Whilst we are aware that processes were being developed during the course of this evaluation in this regard, it is worth addressing here the central issue of 'client confidentiality' that was raised as a concern by staff around recording client information. Client confidentiality is integral to the YAP program philosophy, and this is not in question here. From our interviews and meetings with program staff there appear to be, however, confusions around the basic tenets of client confidentiality and the associated issue of recording client information. The primary reason for this was fear of files being subpoenaed (as well as limited resources to do this adequately, and this is addressed further on). This concern has manifested in files containing the bare minimum of information only. The principles of client confidentiality include the non-divulging of information obtained in the clinical/counselling setting to anyone without a valid professional interest, and only then with the client's consent (with some exceptions, which will not be referenced here). This is well understood by program staff. This is, however, a separate issue from keeping up-to-date, signed and dated client files. In their recording, staff can be aware of the possibility of the client (through Freedom of Information) or a third party (such as police) gaining access to the records; this would involve caution around the specifics of what is being recorded rather than to the recording *per se* (Connelly et al., 2003).

CHILD PROTECTION

There is an increasing call for the AOD sector to implement child and family focused practice into service delivery (Dawe et al., 2006; Trifonoff, 2010). There is also recognition of the need for collaboration between the AOD and child protection sector as many AOD clients are also experiencing child protection issues; the AOD treatment workforce can play an important role in ensuring the safety and welfare of clients'

children (Dawe et al., 2006). One of the distinctions of the YAP program is its child and family approach, which includes both the ongoing monitoring of children's wellbeing, and the ongoing referral of children and families to other support agencies.

The YAP program staff are developing increasingly strong links with DCP, have attended DCP 'Signs of Safety' training, and are in the process of developing a Memorandum of Understanding in relation to collaborative work practices. Staff reported, however, concerns around compliance issues in relation to DCP policies and procedures. There is a need, therefore, for internal agency child protection policies to reflect current developments in DCP policy and procedures, and for these to be implemented and supported at the ground level. This would include attention to mandatory reporting laws, Working with Children checks, and working with Indigenous families and children. In addition, for a family sensitive approach to go beyond the treatment environment, it needs to operate across an organisational level to include organisational guidelines for child and family-focused practice.

PROFESSIONAL DANGEROUSNESS

YAP staff work closely with the program's clients, and in many instances form genuine allegiances, leaving themselves open to developing 'professional dangerousness' – where the worker's emphasis upon preservation of the working relationship with the parent, interferes with the professional's ability to respond protectively to harmful situations for the child (Dale, Davies, Morrison and Waters, 1986). Whilst we did not observe direct evidence of professional dangerousness, this was raised as an issue of concern by YAP staff, who appear well aware of the fine line between providing support structures to the adults while at the same time minimising (potential) harms to the children.

CO-MORBIDITY

The prevalence of people experiencing both AOD problems and ongoing mental health disorders has compounded the capacity of the AOD sector to effectively identify and treat co-morbid clients (Roche & Pidd, 2010). The management of parental mental health issues and their corresponding impact on the parenting role needs to be attended to either through improved training opportunities for AOD workers to better address mental health issues, and/or improved liaison with mental

health services (Dawe et al., 2006, p. 48). For YAP staff this is an area where they know they are compromised through lack of experience and/or access to alternative support services in the region. Strategic decisions around how to manage such cases is required.

WORKFORCE DEVELOPMENT

Worker support

Support provided to AOD workers by colleagues, supervisors and organisations is important, as work in this field is often demanding with high workloads, complex work issues and high levels of both stress and staff turnover. Support encompasses a range of factors from supportive management and supervision to sufficient work-related resources, and is considered a particularly important workforce development issue (Roche & Pidd, 2010). YAP staff reported high levels of both peer support and between themselves and Palmerston staff with whom they are in regular contact. Support in this sense referred to generally being available to share concerns or worries, particularly among each other. In the broader sense, a lack of support was reported in relation to line management and higher organisational levels enabling and empowering workers to strengthen the YAP program for both the short and longer term. This includes internal agency development of the various policies and procedures that have been identified as lacking or inadequate, and support in their implementation and monitoring. These issues go beyond individual workers' concerns; rather, they are core components of operating within best practice principles as reported in the literature.

Supervision

Professional supervision is an essential component of best practice, and considered another important AOD workforce development strategy. There are many direct and indirect benefits to this form of professional support, and AOD workers' limited to no access to a formal process of supervision contributes toward detrimental outcomes for themselves and ultimately the clients (Connelly et al., 2003; Roche & Pidd, 2010). Whilst YAP staff commented that they can organise clinical supervision with the Senior Counsellor, it was reported that there is no structured approach to this. In turn, there is a tendency for staff to rely upon the peer supervision and debriefings which occur regularly among themselves. Whilst there was recognition of the supportive

context within which these processes take place, there was also recognition of the need for a more formalised and professional process in order to develop clinical skills and effective practice, and to mitigate against staff burnout.

Evaluation

The evaluation of program effectiveness in informing the development of AOD programs is recommended as an important workforce development issue. On-going program evaluation is necessary to build on best practice and adapt to changing conditions, and necessarily involves initiatives that develop effective partnerships between research and service delivery agencies (Roche & Pidd, 2010). Furthermore, consumer involvement in service planning, delivery and evaluation is crucial for quality improvement practice (WANADA, 2005). For this evaluation, all clients of the YAP program made suggestions for service enhancement, providing an opportunity for service delivery to reflect issues of importance to them.

For the YAP program to institute internal evaluation and monitoring processes, the development of a formal program logic framework is required. This framework would describe the program and identify key activities, goals, outcomes and indicators of achievement of program goals. It should integrate goals and outcomes for both the children and the mother, and be used as a tool for ongoing monitoring and evaluation of the program. Through this process, a more formal framework will be developed around program objectives and outcomes.

Infrastructure support

From a review of documentary material, the funding sources of the YAP program include:

- The Drug and Alcohol Office, Government of Western Australia – core funding of client services in the Great Southern
- The Department of Health and Ageing – core project funding to 01/06/11
- Great Southern GP Network – YAP Intensive to 30/06/2012

In addition, Palmerston Association received funding for minor capital works through the Department of Health and Ageing, Lotterywest and the Great Southern Development Commission (under the Royalties for Regions program).

All YAP staff work part-time, with salaries being paid at lower rates than equivalent public sector rates. Despite this, staffs' commitment to providing as holistic a service delivery as possible means that they nearly always work more than their paid hours.

The paid administrative support for the program is limited to one day per week, and this was reported by all staff as insufficient. This has contributed towards shortcomings in relation to several organisational (for example, maintaining up-to-date client files), and operational process issues.

RECOMMENDATIONS

The following recommendations flow from the previous discussion of the YAP program model and service. They are offered as suggestions for enhancing and strengthening current operations and practices, some of which are dependent upon the YAP program receiving appropriate funding for the important service they offer.

- The YAP program institute an independent case management structure, responsible for the case management initiation, implementation and transition processes and for providing broader support. This would involve a conceptualisation of the model that best suits YAP's clients' needs, and the strengthening of current processes. In addition to evaluating treatment progress from both the client's and worker's perspective, this will contribute towards overall monitoring and evaluation of the service delivery model.
- An internal Child Protection policy to reflect current developments in DCP policy and procedures be developed and support provided to staff in implementation processes. This would necessarily include a formalised internal supervisory structure in order to ensure that staff are supported in decisions relating to child protection issues.
- A comprehensive child and family focused practice framework be developed, implemented and monitored, and for this to be regarded as core business within the Palmerston/YAP AOD service delivery model. This should include a formal child focused program at both locations, in line with what is currently offered in Mount Barker, and would involve a conceptualisation of the principles underlying child and family focused practice.
- Palmerston Association institute a more formal supervision process for all YAP program staff.
- The development of a best practice framework for working with Indigenous clients.

- The need for a coordinated and integrated approach towards clients with comorbidity. This may involve professional training and development for workers, and/or strong, collaborative partnerships with local mental health services.
- Attention needs to be directed towards integrating contemporary evidence-based practices directed towards the treatment of trauma, grief and loss for clients experiencing these phenomena. This may involve professional training and development for workers, and/or strong, collaborative partnerships with clinical counsellors experienced in working within this area.
- For internal program monitoring and evaluation to become a core component of operational procedures. This would involve the development of a formal program logic framework integrating goals and outcomes for both the children and the mother, and be used as a tool for ongoing monitoring and evaluation of the program. Through this process, a more formal framework will be developed around what the program is intending to do/achieve versus what is actually doing/achieving. Client involvement in service planning, delivery and evaluation is recommended.
- YAP staffing levels are reviewed and funded, where necessary, to provide for an internal case management structure, and adequate administrative support.

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APPENDIX I

Table 1: YAP project funding objectives, activities and measures

Objective	Activities	Measures
1. Provide alternative pathways for substance users through harm prevention and reduction strategies	<ul style="list-style-type: none"> • Formal and informal education and information sessions • Outreach counselling/home visits/intensive CfC outreach including child care • Parenting support • Weekly playgroup 	<ul style="list-style-type: none"> • Number and type of presentations and group activities; number of participants attending • Evidence that relevant information regarding harm reduction is made available to all program participants • Number of activities regarding harm reduction strategies
2. Provide case management, treatment and support services by utilising GSCDST nurse, counsellors and child carer	<ul style="list-style-type: none"> • BBV testing and treatment • Outreach counselling/home visits/intensive CfC outreach including child care • Parenting support • Counselling • Formal and informal advocacy 	<ul style="list-style-type: none"> • Number of groups facilitated in Katanning and Mount Barker • Number of participants attending groups each week • Number of individual counselling sessions provided • Number of shared care arrangements (including which agency) • Number of nurse visits to service locations • Number of children attending group activities
3. To identify and address gaps in services related to early intervention and	<ul style="list-style-type: none"> • Outreach counselling/home visits/intensive 	<ul style="list-style-type: none"> • Number of outreach counselling contacts

support for young AOD using parents, children and families	<p>CfC outreach including child care</p> <ul style="list-style-type: none"> • Parenting support • Education and information 	
4. To increase clients' awareness, and encourage use of other support services; invite other support services to attend group activities	<ul style="list-style-type: none"> • Formal and informal education and information 	<ul style="list-style-type: none"> • Number and type of visits to group program by other agencies • Number and description of agencies involved in YAP program
5. To evaluate YAP to ensure the outcomes are achieved	<ul style="list-style-type: none"> • Administer client surveys • Conduct focus group sessions • Gather information for reports • Record information 	<ul style="list-style-type: none"> • Reports completed and data provided to DoHA on time and as required • Reports to contain analysis of data, results of surveys, report on focus group, report on client outcomes



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