



What works with an Indigenous workforce: an evaluation of the remote AOD workforce

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Remote AOD Workforce Program, NT

This paper is a summary of the evaluation report completed for the Remote Alcohol and Other Drugs (AOD) Workforce by Menzies School of Health Research. This formulative evaluation was conducted using an Appreciative Enquiry approach to identify the key strengths of the program and make recommendations about how to improve the program model. The purpose of the evaluation was to assess the extent to which a Remote AOD Workforce has been established and is being supported to *increase capacity for AOD service provision at the local level, and enable appropriate support for clients, carers, families and communities affected by AOD.*

The evaluation drew data from four main sources: 1) a Document Review; 2) Key Informant Interviews with Program and PHC and PCSU staff and other stakeholders (not clients); 3) structured conversations known as “appreciative interviews” during field visits to program sites and 5) group discussions with the Remote Workforce.

Remote Alcohol & Other Drugs Workforce Program background

In 2006 the Council of Australian Governments (COAG) allocated funding to allow the Northern Territory to establish and build capacity of a remote alcohol and other drugs workforce. This preceded the federal government’s Intervention (Northern Territory Emergency Response- NTER- and now Stronger Futures NT- SFNT) (2007-) and the NT Government Alcohol Reform Strategy ‘Enough is Enough’ (2011 -2012). The purpose of the Remote AOD Workforce Program is to support and strengthen an AOD workforce in urban, rural and remote communities to increase capacity for service provision at the local level, and enable appropriate support for clients, carers and their families and communities affected by AOD.

The Department of Prime Minister and Cabinet (DPMC), formerly OATSIH, provides funding to Primary Health Care Services, formerly Remote Health, Department of Health (DOH) and to Aboriginal Medical Services for dedicated AOD workers and a Program Support Unit (PSU) which includes the Workforce General Manager, formerly Coordinator, the Clinical Supervisor, the Training and Education Program Officer, and more recently the addition of a AOD Clinical Nurse Consultant, Workforce Development Officer, Business Manager, and an Administration Officer which is funded through Alcohol and Other Drugs Services. All Remote AOD Workers (‘the workforce’) are part of the program, regardless of whether they are employed in a government or an AMS primary health care centre (PHCC).

AOD Remote Workforce Program goals and objectives

The aim of the Remote Alcohol and Other Drugs Workforce Program is to establish and maintain a sustainable, culturally appropriate workforce that can address alcohol and other drugs issues and its associated harms in the community, and deliver evidence-based services within a primary health care model. The specific goal of the Program, which continues to be met, is to develop and implement a Remote AOD Workforce which is:

- based within a primary health care service
- providing a service to people that currently have limited access to AOD services
- culturally appropriate
- evidence based
- sustainable.

There are at present 38 funded positions. The Territory-wide workforce is supported by an Alice Springs and Darwin based Program Support Unit (PSU). The Remote Alcohol & Other Drugs Workforce Program utilises a ‘hub and spoke’ model where centralised administrative, technical and

programmatic support is provided by the PSU to community workers located in primary health care centres (PHCC). The workers are also supported, and supervised day to day, by the manager of the PHCC or AMS, who communicates regularly with and can call on support from the PSU if necessary.

There was an initial investment of extensive consultation, risk analysis, and development of a service model based on best practice and lessons learned from other initiatives. Very early in the life of the Program a working partnership was established with senior clinicians and experienced researchers with expertise in Aboriginal mental health and substance misuse issues. There was also investment in widespread consultation and developing a model where plans and priorities are developed locally. This has resulted in the program objectives being well understood and highly valued across both Government and Aboriginal Community Controlled Health Organisations.

Overall the model was found to be an effective means of providing support to a stable, local workforce that contributes to ensuring evidence based services are accessible to individuals and communities affected by AOD.

The main contributors to program effectiveness are related to: good governance; robust, systematic communication, support and technical assistance; regular external clinical supervision and the development of a professional identity as an AOD worker.

The Program Support Unit (PSU) has developed, documented and implemented a clinical governance framework for the program. The framework articulates roles and responsibilities, levels of accountability and operating procedures for the program and the partnership with Primary Health Care Centres (PHCC). There are numerous systems that contribute to the good governance of the program. Responsibilities are clear and accountability mechanisms are varied and well established.

The success of the program is largely due to robust, systematic communication, and the support and assistance provided by the PSU. The communication channels facilitate regular sharing and communication between the PSU and the workers, as well as communication directly between workers. Communications were described as 'warm' and 'respectful'. Team building activities that foster a sense of belonging and build trust among the workers and the PSU staff are incorporated into regular fortnightly teleconferences, face to face twice yearly Forums, and multiple professional development opportunities throughout the calendar year.

Forums

Topics for the forums for regular discussion are drawn from the priorities set by the workers. The workers know what to expect at the face to face Forums and the PSU staff running the Forums appear well organised and relaxed. This creates a low stress, relaxed atmosphere for everyone that facilitates learning.

Clinical supervision

All Remote AOD Workers receive monthly clinical supervision. The workers report that clinical supervision with an independent supervisor with relevant AOD training, experience, skills and knowledge, (not someone they work with day to day at their PHCC), provides them with an ongoing, structured opportunity to review their work practices, a safe space where they can explore and express their feelings about the work and objective feedback and guidance related to work issues and decisions. They appreciate this feedback coming from someone with positive regard for them and an understanding of their role in the community and the PHCC. Several AOD workers mentioned the support they have received during clinical supervision to help them deal with critical incidents such as the suicide of a client, a series of stressful work and/or community events that affected them personally, public criticism or humiliation, exposure to particularly horrific or shocking sights or events.

Role identification

The workers demonstrated a high level of clarity around their roles and the purpose of the Remote AOD Workforce Program, and the role of the Program Support Unit. It is evident that the AOD workers self-identify as health professionals and are recognised as professionals by those around them. There is considerable anecdotal evidence that the workforce is willing to stay available to even the most

difficult to reach clients. Workers interviewed for the evaluation attribute this to the skills and confidence they have developed as a result of the training and support they are provided with.

The majority of the respondents interviewed indicated that the PSU provides the right type, quantity and quality of support to enable the AOD workforce to undertake basic planning and reporting. The addition of an AOD worker provides an opportunity to bring a broader primary health care focus to the work of a PHCC, including components such as prevention, outreach and community development which may otherwise be missing from or limited.

Impact of the program on capacity to respond to AOD issues at the community level

Improving access to AOD services

The impact of the program is difficult to measure in conventional terms, and this evaluation has focused on assessing whether or not the program has achieved the stated objectives rather than on the impact of having workers based in the community. However during the evaluation many anecdotes emerged that provide some insight into the impact of having AOD workers working within remote communities. They also demonstrate the ability of the workforce to generate, not only implement, good practice consistent with the evidence base.

Sustainability

In terms of sustainability, the workforce is supported to deliver services in both personal and practical ways such as: professional development, peer support, advocacy for their program area, advice on career pathways and training opportunities. Finally, in terms of best practice, the PSU has produced tools and resources which support best practice in both service delivery and community development which have been widely embraced and utilised. It would be difficult to sustain the workforce without specific funding, however the benefits of having local people with the skills to source their own AOD related information should provide long lasting benefits to the community.

Summary and recommendations

The program has increased the capacity of the primary health care services to respond to AOD issues locally. All workers are providing a service to people that previously had limited access to AOD services, through a mixture of community and client/family based work. The program has improved access to AOD services for people in remote communities by: increasing the willingness of health professionals to conduct AOD screening in a primary health care setting; establishing new and strengthened referral networks and partnerships with other local service providers; providing support and transport for people wishing to leave their communities to access detoxification and rehabilitation services; increasing willingness to address AOD issues among difficult to reach people and their families; providing consistent, supportive follow up for those returning from treatment. In summary, the program successes have been attributed to:

- investment in developing an evidence-based program and service model
- appropriateness and effectiveness of the program design
- good governance
- robust, systematic communication, support and assistance in areas related to AOD
- regular external clinical supervision
- developing a workforce with a professional identity and clear role
- effectiveness of PSU support for planning, monitoring and reporting.

In summary, the model and the reasons for employing local Indigenous workers rather than nurses is consistent with the themes and issues that emerge from the literature about the priorities and directions of health care in rural and remote Australia and reflects an approach which is now recognised as best practice. (Health Workforce Australia, 2011) The model contributes to ensuring the

remote AOD workforce is providing services that are culturally appropriate, locally initiated and supported and therefore sustainable. The hub and spoke, partnership based model appears to meeting the needs and expectations of the partners, and providing consistent and relevant support to the Workforce. There is no evidence of the members of the partnership 'pulling in different directions', and significant evidence of mutual respect, appreciation and cooperation. In summary, the program is effective and the model is robust, meeting the needs of the partnership members and achieving the program objectives. No major changes are recommended, however there are several suggestions for how the program could be improved, building on the solid foundation that has already been established.

1. In order to avoid key personnel dependence, the program should continue to develop and document systematic models of communication and practice that build on the organisational culture developed within the program. This work is already underway, and communication systems within the program are well developed. It may be possible to ask the workers to take it in turns to host segments of the teleconferences, or to take responsibility for planning and facilitating sections of the Forum, for example.
2. Several AOD workers mentioned the support they have received during clinical supervision has been very valuable and several workers thought it would be good to discuss these types of issues in small groups during the Forums, with others that have experienced something similar. A group supervision or facilitated reflective practice session could be offered.
3. The effectiveness of the overall program efforts may be limited in the locations where workers don't have an operating budget, or find it difficult to source extra/external funds to do community development work or culturally appropriate engagement work. It may be beneficial to provide training on how to leverage funds and external resources, or some workers could participate in small grant writing workshops.
4. All respondents agreed the resources (assessment tools, the community development framework, the *Yarning About...* series of tools etc) are relevant and appropriate for an Indigenous audience. These tools could be validated for use with Aboriginal people, and then shared beyond the program.
5. As the Working Group regains momentum and once they have caught up with what has happened in the program over the last few years, it may be useful to actively engage members in planning and decision making.
6. To promote continued understanding of and links with the Program among other service providers (where staff turnover is likely to be high) the PSU and workers could hold Community Open days/Program Promotion Days. This would help to ensure other service providers are aware of the Remote AOD Workforce and make links and extend referral options . This has been done in the past, and was considered valuable.
7. The PSU should continue to advocate for policy changes for a more enabling environment – for example PATS for transport to detoxification and rehab, timeliness of acceptance of people into treatment programs, remove barriers, such as the criminal history exclusions, to accessing residential treatment etc.

The program is at a point where it could benefit from discussion of some outcome indicators or measures of success for the Program. Since the completion of the evaluation, many of the recommendations have been implemented, including the development of a program logic, a Remote AOD Worker Leadership Group has been developed whom take greater responsibility for the direction of the workforce including forum involvement and decision making, a mentoring program being formalised, and tool validation is planned for the next financial year. The program has since been provided with additional funds from the Commonwealth, which has enabled the Program Support Unit to grow and provide greater support to a growing workforce as an additional 15 workers will be funded in remote communities in 2015-16. There is also the plan to have the workforce model documented in a series of journal submissions. The program will be evaluated again in 2016-17 possibly using a

social return on investment approach to examine the program's impact more specifically in remote communities.

References

Health Workforce Australia. (2011). *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*. Health Workforce Australia.

Roberts, Jenne. (2013). *Remote Alcohol and Other Drugs Workforce Program Evaluation*. Menzies School of Health Research.

Presenters

Diane Mayers is a Remote Alcohol & Other Drugs Worker in Elliott, Northern Territory with the Remote AOD Workforce. A local Tennant Creek woman (Warramungu) with extended family in Elliott, she provides a local, culturally-appropriate AOD service within the Primary Health Care Centre. She has worked in AOD for over 10 years and has witnessed the impact of substance misuse on her family, friends and township and wanted to make a difference to support the next generation of leaders in the Barkly region. Diane is passionate about her work in the community, and believes from little things, big things grow.

Asman Rory is a traditional Garawa and Gudanji man from the Gulf of Carpentaria, and a Remote Alcohol & Other Drugs Worker with the Remote AOD Workforce in Borroloola for 6 years. Asman has learnt from his Elders and lives what has been practised by his ancestors, passing onto his children and family the lore/law, ceremony, hunting his grandparents taught him. Asman uses his ancestral knowledge to help young people in Borroloola understand and learn about the effects of alcohol and other drugs and its consequences as part of his life and role as a Remote AOD Worker.