Remote Alcohol and Other Drugs Workforce Program

Interim Report

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Associate Professor Tricia Nagel
Menzies School of Health Research
Clinical AOD Director

Jennifer Frendin
Remote AOD Workforce Coordinator

Jasmine Bald
Remote AOD Program Support Officer

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Executive summary

- Indigenous people have high rates of substance misuse and co morbid disorders such as chronic disease and mental illness yet there is limited access to integrated community based substance misuse treatment services in the Northern Territory.

- The recent national social and emotional well being (SEWB) survey showed that only 12% of those with a substance misuse disorder sought help, that help was usually sought through primary care settings, that young people were less likely to receive treatment, and that young men and older men were the least likely to receive treatment.

- The Remote AOD workforce is well positioned to provide a framework for treatment services which meet community needs and is directly aligned with Objective 3.1 of the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan.*

- The current 'hub and spoke' model of service delivery provides central administrative and programmatic support to workers in distant sites. This workforce extends across both government and non government services and works within a primary health care framework.

- The key challenges to the workforce can be divided into those of governance, sustainability, and implementation of best practice. The evidence base for effective treatment models is limited and workforce concerns include career structure, worker stress, professional isolation, uncertainty of funding, and high staff turnover.

- Four programs operating within the last decade provide insight into the way forward. The *Living with Alcohol* program, the *Aboriginal Mental Health Worker program*, the *ABCD program* and the *AIMhi program*. The Remote AOD Workforce Program has the opportunity to translate this relevant research into action as recommended in the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan,* and to bring action research to service delivery.

- The Workforce has developed a Best Practice Model incorporating the AIMhi approaches and an evaluation framework adapted from the ABCD program. This interim report finds that the Workforce has progressed well in each area of the Model.

- Despite the impressive achievements of this workforce to date it remains vulnerable to change. The way forward is to stabilize and strengthen the current relationships and model of practice and to build on this momentum. This requires longer term funding cycles and strengthened governance and policy support.

Introduction

Indigenous people have high rates of substance misuse and co morbid disorders such as chronic disease and mental illness. There is increasing awareness of the role of social determinants in the excess burden of disease associated with these disorders: high unemployment, poor education opportunities, overcrowded housing and social disadvantage. Withdrawal services, sobering up shelters and residential rehabilitation services are the major treatment options available in the Northern Territory (NT) and are mostly situated in urban settings. In contrast, there is limited access to community based supportive treatment services. Furthermore, despite the high need, treatment services dedicated to Indigenous needs are scarce, particularly in remote areas.

Access to treatment is a major challenge for people with mental health and substance use disorders across Australia. The recent national social and emotional well being (SEWB) survey showed that one third of those with a mental disorder did not seek help from services. Seventy percent of those who did seek help sought help through primary care settings [1]. Comorbid disorders, in particular mood disorder and substance use disorder, were highly prevalent and linked with increased use of services. Meanwhile, the disorder linked with the least likelihood of seeking help was that of substance misuse. 12% of those with a substance use disorder alone seek treatment. Young people were less likely to receive treatment and young men and older men were the least likely to receive treatment [2]. A simultaneous review of the annual economic burden of substance use disorders suggested that only a very small proportion of this burden is being averted by treatment because treatment rates are so low [2].

The SEWB survey also asked participants to identify whether or not they believed that their needs had been met through treatment. In terms of meeting perceived needs the survey showed that the needs least likely to be perceived as met are social interventions and skills training [3]. These survey findings strongly support the establishment of services which promote access, which are focused and available at primary care level, which address social interventions, which especially target youth and men, and which implement what is known in terms of effectiveness to support improved outcomes. The Remote AOD workforce is well positioned to provide a framework for treatment services which meet these needs and is directly aligned with Objective 3.1 of the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* [4].

This paper seeks to explore some of the background to the workforce, link the current direction with relevant territory experience and evidence, and present specific recommendations for the next three to five years. It is a draft paper for consultation and is presented to the working group as an outcome of the first three months of the new Remote AOD Workforce Program executive which comprises the Clinical Director, the Workforce Coordinator and the Program support Officer. It is not intended to represent a comprehensive literature review, nor a comprehensive historical exploration. It nevertheless seeks to bring both academic and clinical perspectives to the way forward.

Background

In 2006 funding through the Council of Australian Government was provided to enable the establishment of an AOD workforce tasked with delivering services to remote communities. Funding was allocated to specific Department of Health and Families (DHF) Remote Health Centres and Aboriginal Medical Services to develop and implement a Remote AOD Workforce framework. The workforce aimed to be: manageable and sustainable, working within a primary health care model, culturally appropriate, and delivering evidence based services. There are 20 funded positions for 2009 - 2010 based at Borroloola, Daly River, Gunbalanya, Umbakumba (DHF services) and Anyinginyi, Central Australian Aboriginal Congress, Danila Dilba, Katherine West Health Board, Miwatj Health, and Wurli Wurlinjang (Aboriginal Medical Services).

Most of these positions are currently filled. The majority are filled by Indigenous workers and the skill level ranges from Certificate II to Certificate IV (usually AOD training). One recent Indigenous employee has degree level qualifications in AOD gained in Canada working in community based treatment services for the North American Indian population. The workforce currently employs three non Indigenous workers who have nursing, occupational therapy and AOD qualifications.

The workforce is supported by a central program executive which, as mentioned earlier, includes the Clinical Director, the Workforce Coordinator and the Program Support officer. These three positions are employed within the Department of Health and Families Remote Health and AOD Programs. The program is also supported by a Working Group consisting of key stakeholders from a diverse range of agencies i.e. Remote Health, Alcohol and Other Drugs and Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) to ensure processes and practices put in place across the NT Remote AOD Workforce are consistent and agreed upon by all parties.

The current model represents a ‘hub and spoke’ model of service delivery. Central administrative and programmatic support is provided to workers in distant sites. Fly in fly out specialist back up (coordinator / clinical director/ trainer) is provided to community workers on the ground, who are embedded in local services which provide on-the-ground service support. Although this model is familiar and similar to the delivery of health services across the Northern Territory there are a number of aspects of the model which are unique.

A developing workforce

This workforce is unusual in a number of ways: it extends across both government and non government services, it introduces dedicated AOD workers to primary health care settings, and it represents an opportunity to join together best practice with recent NT research.

The key challenges to the workforce can be divided into those of governance, sustainability, and implementation of best practice. In terms of governance there is a need to ensure that the workforce is provided with regular clinical supervision and clinical review, clarity of management accountability and professional responsibility, and clarity of role. In terms of sustainability the workforce needs to be supported to deliver services in both personal and practical ways such as: professional development, peer support, advocacy as a group, career structure, travel and

accommodation support. Finally, in terms of best practice there is a need to provide tools and resources which support best practice in both service delivery and community development. These tools include assessment and care planning tools, educational resources, guidance with respect to community development principles, data collection tools and information systems to support planning and decision making. In addition, the workforce requires system support and strong governance.

To develop a sustainable workforce in remote communities in the NT also requires that past experience is taken into account in planning, that models of service delivery which have not worked well in the past are not simply recycled, and that new evidence is integrated into new systems. Continuous quality improvement principles provide a framework for evaluation which can inform progress toward improved outcomes.

Workforce challenges

This workforce faces a number of challenges. The first of note is that there is a lack of an evidence base to inform best practice models. Indigenous AOD research has focused mainly on examining prevalence and risk factors, and measuring the impact of legislation and supply reduction strategies. There is little to guide development of demand reduction strategies or models of community-based treatment services. In addition there are: challenging partnerships to be developed and maintained, issues of career structure, concerns about worker stress and vulnerability to blame, professional isolation, stigma related to AOD issues, uncertainty of funding, short term contracts, and high staff turnover. All of these are familiar challenges in the NT remote setting.

Challenges identified by the current workforce at the recent face to face meeting in Alice Springs were as follows: that having different reporting requirements and paper based and electronic records is cumbersome, that patient assisted travel is limited, that there are few local safety houses and treatment centres, that there is a need for both male and female workers in communities to provide culturally appropriate services, and that there are ongoing housing and staff accommodation issues. The search for strategies to address these challenges must begin in the Territory, where this unique blend of widely dispersed remote communities and multiple cultural and language barriers to health service delivery is found.

Learning from past experience

In terms of experience in the NT there is a range of relevant research and evaluation activity which is pertinent. This includes four programs in particular which provide insight into the way forward. The *Living with Alcohol* program was implemented in the NT between 1992 and 2002. The Aboriginal Mental Health Worker (AMHW) program began in 2000 in response to the perceived need to provide community based mental health services. The *ABCD program* grew out of coordinated care trials begun in the late 90's in response to the need to provide coordinated care in remote primary care settings for people with chronic disease, and the *AIMhi program* of research (2003-2009) was established to develop best practice pathways in Indigenous mental health in primary care settings.

Living with alcohol (LWA) program

The LWA program was introduced in 1992 and was initially funded by the imposition of a small levy on alcoholic beverages sold in the Northern Territory (NT). LWA programmes and services continued to operate to 2002. Two evaluations were conducted, the first in 2001 and the second in 2004. The evaluation results found that the LWA program resulted in significantly reduced alcohol-attributable deaths and financial cost savings to the NT. The key take home message from this 10 year program was that interventions can make a difference, and that the components of success include a focus on treatment services and broader awareness raising campaigns linked with supply reduction through alcohol taxes [5]. Successful treatment interventions and their effectiveness was not addressed in either evaluation, however the evaluation of the Aboriginal Mental Health Worker program below adds detail to the challenges similar remote treatment services face.

Aboriginal Mental Health Worker program

In 2001, the Top End Division of General Practice (TEDGP) gained funding under the Australian Government's *More Allied Health Services* (MAHS) program to employ Aboriginal Mental Health Workers (AMHWs) alongside General Practitioners in five remote health centres. Through partnership with *beyondblue* and the Alcohol Education and Rehabilitation Foundation (AERF) the number of workers and health centres was increased to three further centres. The general objective of the AMHW Program was to develop the role of the Aboriginal Mental Health Worker as a member of a community-based mental health team in participating communities, linking local cultural knowledge and expertise of AMHWs with general practitioners. The program evaluation in 2003 highlighted a number of areas in which the program achievements were limited [6]. The report described limitations in terms of: communication of client social and cultural issues, 'two way' collaboration with workers, integration into health centre models of practice, career development, and meeting the need to have both male and female AMHWs available.

> *'Strengthening the supports for clinical practice, involving AMHWs in collaboration between practitioners in the community and in the centrally located facilities, is a necessary foundation for their role in the community, and a basis for ongoing development of their skills'. (P. 123)*

The report concluded that there was a lack of system support for the program including training and supervision, management and administrative support and a secure model of funding [6]. These shortcomings are important sign posts for the new AOD workforce and provide opportunity to predict, avoid and manage similar issues.

The Australian Integrated Mental Health Initiative NT

The Australian Integrated Mental Health Initiative (AIMhi) in the Northern Territory worked with Aboriginal Mental Health Workers (AMHWs) from 2003-2009 to develop culturally appropriate assessment and treatment tools for remote community settings [7]. It sought to overcome challenges of distance, language, literacy and worldview [8-11].

The AIMhi program of research developed tools for mental health promotion, tools for care planning, and an Indigenous[1] mental health training course which was then evaluated [12]. The mental health training resulted in significant improvements in confidence and understanding of Indigenous mental health in service providers from a broad range of backgrounds. Having begun with strong support within the Preventable Chronic Disease Program (in recognition of the high prevalence of comorbid mental health and chronic disease) the training has increasingly been sought after by AOD programs (in particular the West Australian Network of Alcohol and other Drug Agencies) in recognition of the high prevalence of comorbid mental health and substance misuse.

The care planning tools were incorporated into a brief psychological intervention (or 'low intensity cognitive behavioural intervention') which was tested in a randomized controlled trial. A mixed methods design was used to test the effectiveness of the intervention called Motivational Care Planning. An exploratory phase of qualitative research was followed by a nested randomised controlled trial. 49 patients with mental illness and 37 carers were recruited to the trial which compared Motivational Care Planning (n=24) with a clinical control condition (treatment as usual, n=25). 82% of the clients used alcohol and/or marijuana and of those people 92% met criteria for psychological dependence (Appendix).

The results found significant improvements in wellbeing, mental health and substance dependence which suggest that MCP is an effective treatment for Indigenous people with comorbid mental illness. These findings confirm the results of other studies which showed improved outcomes in response to problem solving, motivational interviewing, cognitive behavioural therapy and self management interventions. The consistent theme is that brief therapies make a difference and that integrating substance use and mental health treatment is a successful approach. These findings are directly relevant to development of remote AOD workforce and community based treatment. Low Intensity CBT interventions are particularly well suited to the settings and skills of this workforce, and the tools and the training were adapted to the unique NT remote context.

The AIMhi program also collaborated with the ABCD project to develop continuous quality improvement tools for mental health service delivery in primary care. These tools and processes are also appropriate for adaptation to the AOD context. The ABCD research program is described in detail in the next section.

Audits of Best practice in Chronic Disease (ABCD) program

Training alone is not enough to change health professional's behaviour and to introduce new approaches to practice. Multi faceted interventions are needed which include engagement of staff in development of training and feedback of outcomes [13]. ABCD is a CQI project tailored to meet the needs of services providing primary health care to Aboriginal and Torres Strait Islander people that has been operating since 2002. It has since expanded to more than 60 sites around Australia.

[1] For the purposes of this paper the term Indigenous is used to refer to Aboriginal and Torres Strait Islander peoples and recognizes their rich diversity of culture.

The aim of the project is to improve chronic illness outcomes in Indigenous primary health care settings and to supports services to assess and improve their systems for the delivery of best practice care. The project demonstrated that continuous quality improvement processes and tools are appropriate to and well accepted in Indigenous primary health care services. It also resulted in improvements in health centre systems delivery of services according to best practice guidelines, and intermediate health outcomes (such as better control of blood glucose and cholesterol) [14].

The principles of CQI provide a framework of evaluation for the AOD Remote Workforce Program. Participatory action research involves service providers in each step of the process. Such a model is relevant to Indigenous primary care settings which particularly need to harness community involvement to drive change and to find empowering models of health care. The ABCD CQI principles can be blended with the experience and expertise of AOD Remote Workforce Program to develop a sustainable evaluation process.

Opportunity

Developing an Indigenous workforce in communities provides an opportunity to develop primary care based services for AOD [15], to overcome worldview difference [16], to promote health literacy and compliance through relationship [17], to use cultural identity as a health promotion tool [18] to develop empowerment and ownership within community [19] and to promote access to those in need [1]. It provides the opportunity to translate relevant research into action as recommended in the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* and to bring action research to service delivery [4]. It also provides opportunities to learn from previous endeavours and to predict a need for strong clinical leadership, clinical supervision, service level agreements which support the workforce and a best practice framework.

The current Clinical Director is Head of the Healing and Resilience Research Division at Menzies School of Health Research and has 27 years contextual experience in the NT including 5 years as Director of Psychiatry Top End Mental Health Services. The Remote AOD Coordinator has been in the health industry for thirty years. Twenty of these years have been within remote health, mental health and AOD clinical and quality improvement roles. The program executive thus has strong clinical expertise and is able to bring both clinical leadership and research rigour to the development of the workforce program.

Best Practice Model

The past eighteen months have seen two streams of parallel activity in the workforce. One stream of activity has focused on funding, consultation, networking, planning and recruitment. This stream has had marked success. The twenty positions have been filled and of those recruited the vast majority has stayed. The second stream of activity has been the definition of a model of best practice and the development of supporting tools and processes. These tools have been reviewed and refined and placed within a continuous quality improvement framework. The best practice model is outlined below (Figure 1).

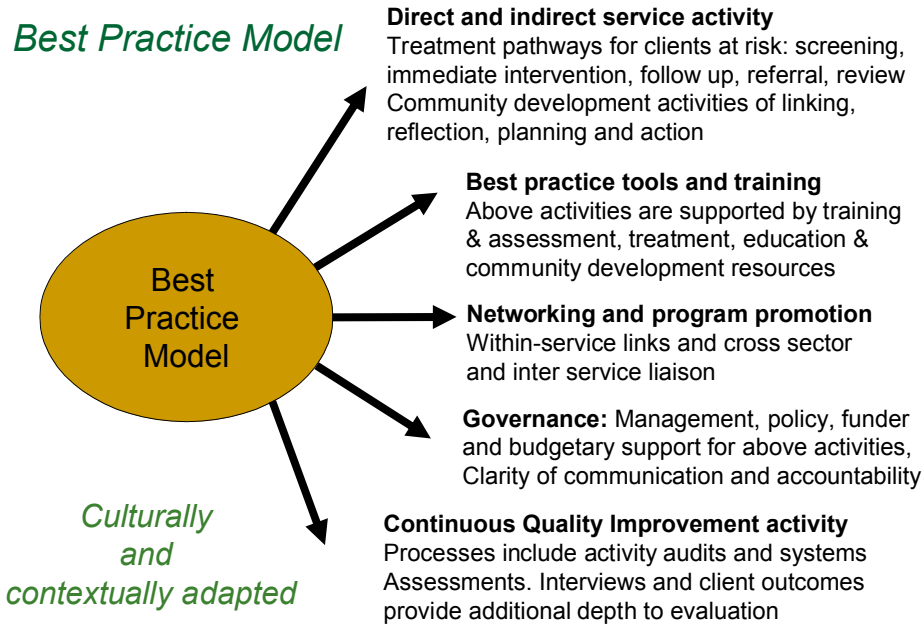

Figure 1. Best Practice Model in community based Indigenous AOD services

Service activity

A key feature of the remote workforce AOD worker role is that it comprises two distinct related sets of activity – direct service delivery and community development. The model defines best practice in each of these areas. Best practice in service delivery is defined by the best practice pathway below in Figure 2 (additional detail given in Appendix 1) and comprises eight activities from assessment to feedback. Best practice in community development is defined by four activities: community networks and linking, community self assessment and reflection, planning and community action and evaluation of these activities. Community development is a key strategy for improved community wellbeing which is defined in the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* as follows:

> *A growing body of research demonstrates that social capital—resilience, the capacity to work collaboratively, the ability to recognise communalities, connections that bridge differences within a community, and the ability to resolve conflicts—is profoundly important to people's overall sense of emotional and social wellbeing. In preventing alcohol, tobacco and other drugs related harm, community and social capital are factors of crucial significance* [4].

The following definitions further outline the concept of community development and the way in which the concept can be operationalised.

> *An Indigenous paradigm for community development may be defined as: working with communities to assist their members to find plausible solutions to the problems they have identified. This must be conducted in an environment that advocates full and active participation of all community*

members in order that we understand and own skills to develop culturally appropriate programs/projects and services for our communities [20].

Community development, in very simple terms, is the process of developing social capital. It is a process that emphasises the importance of working with people as they define their own goals, mobilise resources, and develop action plans for addressing problems they have collectively identified [21].

The deconstruction of 'community development' into its component actions is an important and innovative contribution to this field of industry. Introducing a framework and developing best practice principles for community development may assist in highlighting the importance of networking which is grounded within the community and focused on community capacity building. This provides a means of avoiding the development of multiple smaller networks which are project or personality based and short lived. It also provides a means of guiding and upskilling workers who have not been trained in community development. The major focus of worker activity thus far has been engagement, liaison, networking and health promotion activity.

The development of a model and a clear role for the workforce is supported by suitable tools and resources to equip the workforce to deliver best practice. The 'toolkit' has been under development for 18 months and progress is detailed below.

Tools and training

The workforce program has developed a best practice 'tool kit' and delivered these tools to the workforce (Figure 2.). The assessment tools, screening tools, and treatment and education tools use plain English and aim to adapt to the needs of the workforce and their clients and community. An important accompanying tool is the Best Practice Pathway which outlines the steps in management of high risk clients (Figure 3). A *draft activity journal* has been developed which outlines the AOD worker role in service delivery and community development. This is a potential training and supervision tool for review of best practice activities. The dual role of workers (service delivery and community development) encourages outreach and social interventions, and acknowledges that the proportion of time spent in each activity will vary according to individual worker experience, expertise, and community context. The workers have also been provided with data collection tools and a comprehensive library of education resources. The current set of tools incorporates aspects of the AIMhi approach (pictorial and 'two way') as well as other pictorial prompts. These tools are currently being evaluated and refined through consultation with the workers.

In terms of training, a skills audit has been completed and all workers are linked with appropriate training through relevant training organizations. The workers have opportunity for training and clinical supervision through regular teleconferences and opportunity to access education through workshops and conferences.

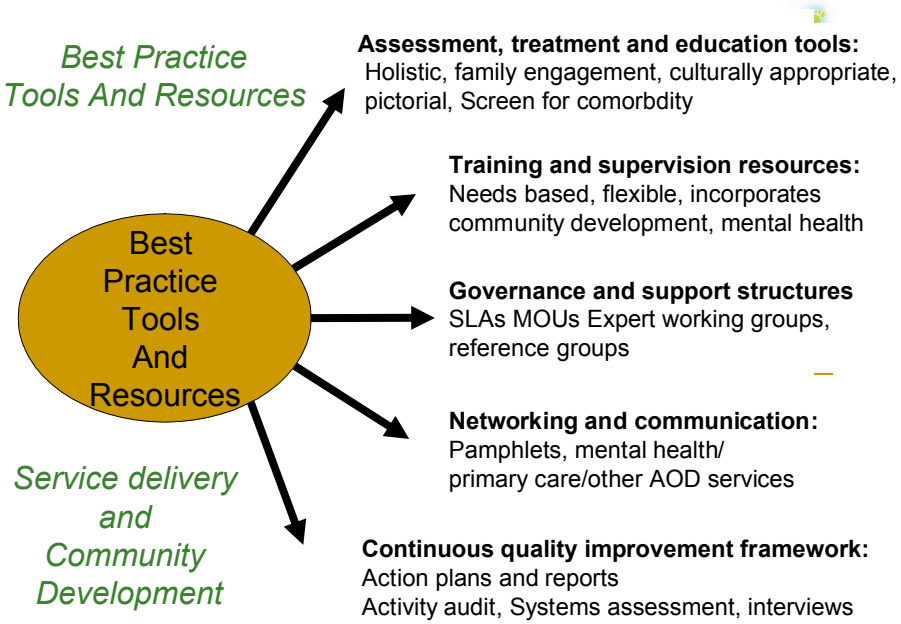

Figure 2. Tools and Processes to support the Best Practice Model

Networking

The main focus of networking thus far has been development of key relationships between services and the program coordinator, which has allowed recruitment and line management accountability to be put into place. The importance of the workforce networking and supporting each other cannot be under stated. The networking system includes teleconferences, phone and email support, a newsletter, forums and conferences. The teleconferences run on a fortnightly basis which unites the team across the Territory on a regular basis. The forums and conferences have been a part of bringing the workforce together to build up relationships. The strengths of this workforce are the ongoing commitment from the workers themselves to ensure the team supports and mentors each other.

Governance

The Program executive has met regularly in the past three months with contact by phone, email and face to face meetings. The coordinator and the clinical director are guided by a Working Party which aimed to meet regularly but has been challenged by lack of a quorum on a number of occasions. There is room to improve communication pathways between the funder, the program executive and the Working Party.

Continuous Quality Improvement

The range of skills, language and literacy of the workforce challenges comprehensive data collection. This reflects findings of the AMHW program evaluation and AIMhi audits of AMHW in patient activity [6, 22]. Success in this area will result from appropriate tools, clinical supervision and training. Education about the importance of recording service activity in terms of continuity of care, collaboration and quality control needs to be ongoing and delivered with recognition that training alone does not change behaviour [13]. The Workforce Program has developed data collection tools and data base support for analysis of activity data within a *draft CQI framework*. The draft framework has been informed by the Guidelines for Evaluating Alcohol and Other Drug Education and Training Programs (National Centre for Education and Training on Addiction, 2004).

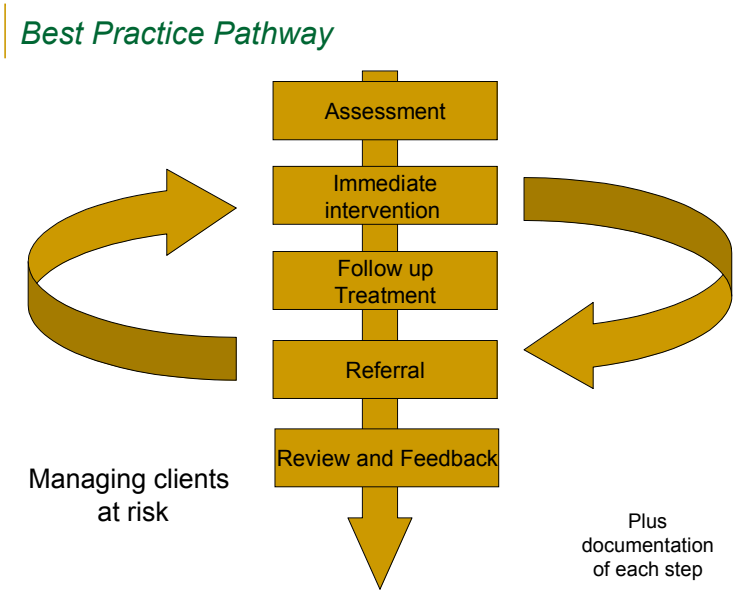

Figure 3. Best Practice Pathway

The *draft CQI framework* follows the ABCD timelines of a yearly cycle of evaluation implemented over 3 – 5 years. In the draft framework, yearly feedback of file audits and system assessment analysis takes place. The workforce sets goals for the next year through focus group activity. The draft framework has four components.

- Best Practice File and Activity Audit
- Best Practice Systems Assessment
- Key informant interviews
- Client outcomes over time

The file audit would be seeking evidence of application of the six Best Practice Pathway principles in the file: assessment, immediate intervention, follow-up, treatment, referral, review and feedback. The activity audit would examine data relevant to the four aspects of community development activity: making community links, observation and reflection at community level, planning and action at community level and evaluation of activities.

In addition to the activity audits above, a 'system assessment' is proposed (Appendix 2) which reviews the system across five domains: Access, Assessment and treatment, Continuity of care, Community engagement, and Continuous quality improvement. Each domain is examined from four perspectives: physical space and environment, service provision, management and service-wide activity, funder and policy perspectives.

Looking ahead

The best practice model allows clear recognition of the current achievements of the workforce. In terms of service activity, tools and training, networking, governance and CQI there is evidence of good progress in all areas as detailed above. The next phase will require the program to build on this strong foundation and in particular strengthen the following areas of Best Practice.

Service activity

Refine assessment tools and recording processes
Introduce client screening and outcome measurement
Explore engagement strategies for youth and older men
Continue to promote awareness of Fetal Alcohol Syndrome and related disorders

Tools and training

Continue to develop and refine individual training goals and supervision contracts
Implement regular clinical supervision delivered at distance and face to face.
Implement local regular clinical review
Trial an activity diary to record service delivery and community development activity

Networking

Promote the workforce across services and sectors
Continue development of peer and professional support processes

Governance

Strengthen the program executive: increase FTE, and aim for longer term contracts
Clarify communication pathways between funder, executive and Working Party
Formalise service level agreements supportive of the best practice model
Develop an Expert Reference Group of senior clinicians and researchers to provide guidance to the Program executive and the Working party with respect to best practice and evaluation framework.

Continuous Quality Improvement

Refine data collection tools
Establish meaningful feedback of data and analysis to workers and Working group
Refine CQI tools
Implement yearly CQI activities: File audits and systems assessments, focus groups and key informant interviews exploring barriers and enablers to best practice

Conclusion

Despite the impressive achievements of the workforce program to date it remains vulnerable to change. It is held together by the commitment of the coordinator and the program support officer and their relationship with workers and services. The way forward is to seek to stabilize and strengthen the model of practice which has been developed and to build on this momentum. The model of centralized support and a strong executive supporting a distant workforce is particularly appropriate. The workforce is not highly skilled and is thus limited in opportunity and ability to self-advocate. The role is new and vulnerable to blurring under pressure from acute care needs and professional isolation. The focus on developing identity and cohesion across the workforce is an important ingredient for success in the next phase of consolidation of the program. Other key ingredients are continuity of funding and a longer term commitment to the workforce in terms of governance and policy support.

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