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Remote Alcohol and Other Drugs Workforce Program Evaluation May 2013

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Remote Alcohol and Other Drugs Workforce Program Evaluation

for

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Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory AMSANT is the peak body for ACCHO in the NT
AOD	Alcohol and other Drugs
COAG	Council of Australian Governments
CSW	Community support worker
DOH	Northern Territory Department of Health
DOHA	Department of Health and Ageing
NT	Northern Territory
NTER	Northern Territory Emergency Response
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PSU	Program Support Unit
PHCC	Primary Health Care Centre

Executive Summary

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 (AOD) workforce. The aim of the Remote Alcohol and Other Drugs Workforce Program (RAODP) is to establish and maintain a sustainable, culturally appropriate workforce that can address AOD issues and associated harms in the community, and deliver evidence-based services within a primary health care model. The purpose of the evaluation is 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.*

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 program meets the objectives in that the remote workers are:

- based within primary health care services located in remote communities with significant alcohol and other drug issues
- providing a service to people that previously had limited access to AOD services
- culturally appropriate
- providing evidence based services

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 face to face Forums.

Topics scheduled 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.

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.

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.

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.

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. In part the difficulty of assessing impact relates to the absence of written program logic with a focus on client and community outcomes.

Program Background

The consumption of alcohol plays a large part in Australian society. It is often used in social situations, to relax, and as a major part of celebrations and recreational activities. However, the consumption of alcohol in Australia gives rise to, or contributes to, a number of costs including: alcohol-related violence and crime; preventable disease; death and disability from injuries; and negative impacts on families and communities. (The SA Centre for Economic Studies, 2009)

Alcohol is also a serious public health issue for both Indigenous and non-Indigenous Territorians. The Northern Territory has one of the highest per capita alcohol consumptions in the world Adults in the Northern Territory on average consumed 15.07 litres of pure alcohol in 2004/05, 53 per cent above the national average. Aboriginal consumption is estimated to be around 16.9 litres and non-Aboriginal consumption 14.5 litres. A study of alcohol related harms in the NT concluded "If the Northern Territory were a country then it would have the second highest rate of per capita alcohol consumption in the world." (The SA Centre for Economic Studies, 2009)

The high burden of disease caused by alcohol and other drugs (AOD) issues in Aboriginal people is well documented. Alcohol related deaths and hospital admissions are also considerably higher in the Northern Territory than they are nationally. For example Alcohol-attributable deaths occur in the NT at about 3.5 times the rate they do in Australia generally; rates in non-Aboriginal people were about double the national rate, while they were 9–10 times higher in Aboriginal people. There were 2319 and 2544 alcohol-attributable hospitalisations in the NT in 2004–05 and 2005–06, respectively. This is more than twice the national rate. (Skov, Chikritzhs, Shu, Pircher, & Whetton, 2010)

Remote AOD Workforce Program History

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.

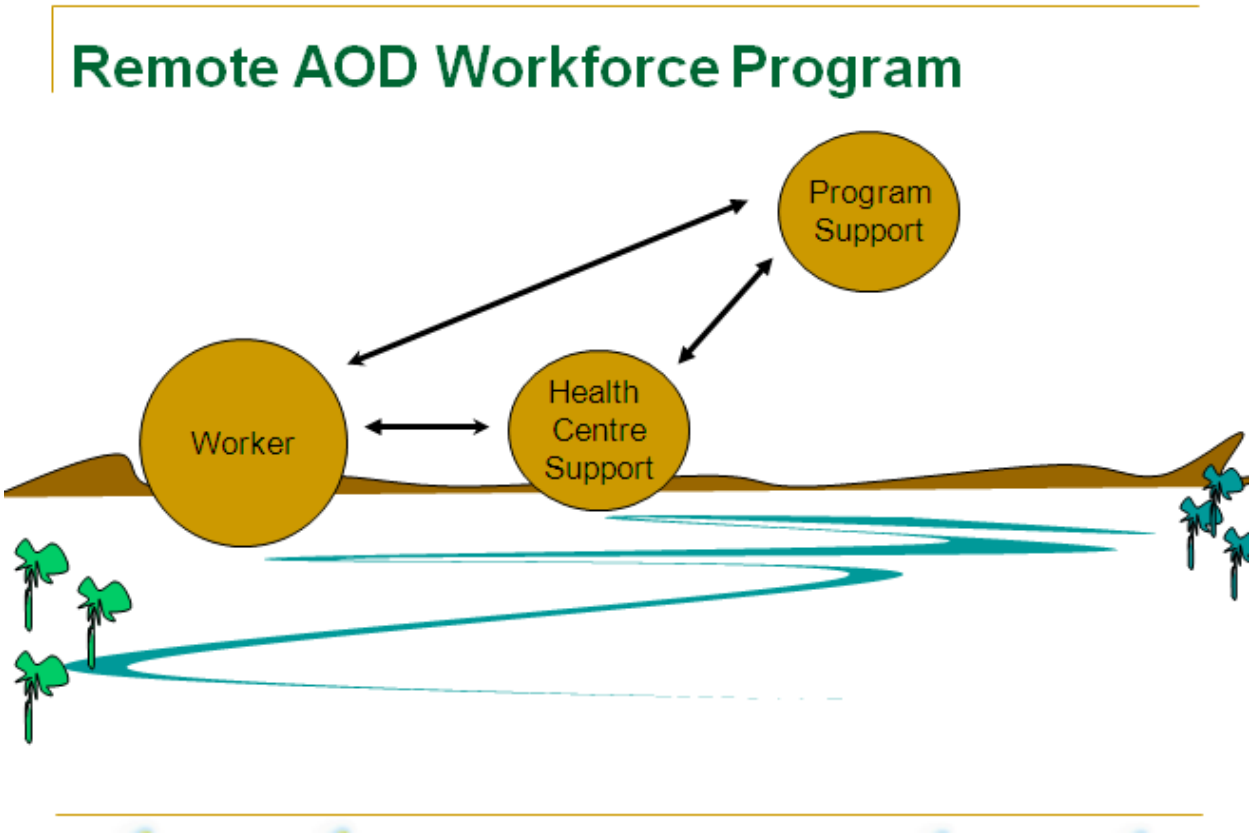
OATSIH provides funding to Remote Health, Department of Health (DOH) and to AMSs for dedicated AOD workers and a Program Support Unit (PSU) which includes the Workforce Coordinator, the Clinical Supervisor and the Training, Education and Clinical Program Officer, which is funded through Remote Health. 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 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 27 funded positions. The Territory-wide workforce is supported by an Alice Springs 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, who communicates regularly with and can call on support from the PSU if necessary.



The workforce are managed and supported through each PHCC as part of a primary health care team. A Service Partnership Agreement (SPA) between the PSU and the DoH health centres and AMS clarifies the mutual expectations about the respective roles and responsibilities of the AOD Workers, the manager and the Remote AOD Workforce Support Unit. It documents the mutual obligations and expectations and roles and responsibilities of each party.

There are a number of aspects of the model which are unique. For example:

- The Workforce extends across both government and non-government services
- Centralised program support and supervision is provided separately from day to day line management
- dedicated AOD workers are managed and work within primary health care settings
- The workforce is drawn from the community, rather than from health professionals with specialist AOD qualifications where possible
- The emphasis is on supporting workers with local cultural knowledge to develop expertise in AOD to complement their cultural knowledge and expertise
- The workforce are supported to undertake both direct client services and community development

The workforce is relatively stable. Turnover is low, particularly among those directly employed by the Northern Territory department of health (DOH). Approximately 40% of the workers have remained in their positions since the program's inception.

At present the program is further developing and embedding its community development framework and a continuous quality improvement (CQI) framework in conjunction with the direct client service delivery model. The Program is also creating a suite of resources that can be used by the workforce to enable them to deliver a range of services to clients including brief intervention through to comprehensive assessment. The workforce continues to have the opportunity to embed substance misuse responses into primary health care settings, enabling holistic client care in remote communities.

The role of the Program Support Unit (PSU)

The PSU is responsible for:

- Provision of a Clinical governance framework to support best practice pathways including: tools, training, supervision and advice to the remote AOD workers in day to day engagement with clients, families and community.
- Provision of regular face to face, telephone, and email contact with PHCC Managers to support a collaborative approach to the development of the workforce program.
- Facilitating teleconferences every fortnight which include an education component and feedback and support from AOD workers across the Territory.
- Provision of tools and resources to promote and deliver the AOD service.
- The ongoing reporting to DOH and OATSIH to ensure that the funding for the Remote AOD Worker positions is ongoing.
- Collation of qualitative data on a monthly basis from the workers to ensure reporting requirements are met according to funding agreement.
- Facilitation of skills audit, training, education and professional development through recognised registered training Organisations (RTO) and other specialists, to support a culturally safe and competent workforce.
- Community visits from Remote AOD Workforce Coordinator, Clinical Supervisor and Education, Training & Clinical Program Officer as a part of the ongoing support.
- Advocating for appropriate housing for the AOD Worker.
- Providing other support as required as negotiated.

The role of the Remote AOD Worker

The role of the Remote AOD Worker ('the worker') is to undertake activities that increase the capacity for service provision at the local level, and enable appropriate support for clients, carers, families and communities affected by AOD. Therefore the workers engage in two types of activities:

1. direct client / family service delivery
2. community development

The community development activities are guided by the Remote AOD Workforce Community Development Framework.

The Workforce comprises: DoH health service based staff in Borroloola, Daly River (Nauiyu), Gunbalanya, Jabiru, Umbakumba, Aputula/Titjikala, Elliott/Ali Curung, Angurugu and AMS based staff located in Anyinginyi, Central Australian Aboriginal Congress, Western Aranda Health Aboriginal Corporation, Danila Dilba, Katherine West Health Board, Miwatj Health, and Wurli Wurlinjang.

The majority of positions are filled by Indigenous workers (over 70%), many of whom had no formal background as AOD workers prior to commencement. Currently the qualification level ranges from Certificate II to Certificate IV through to Degree Level. The workforce currently employs eight non-Indigenous workers with nursing, occupational therapy, counselling, social work and AOD qualifications.

THE EVALUATION SCOPE OF WORK:

The purpose of the Evaluation

The purpose of the evaluation is 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.*

It is beyond the scope of the evaluation to consider and assess individual performance of the workforce, rather it will look at the program model and the role of the PSU coordinating and developing 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

The evaluation will consider not only what has happened but also make some recommendations on how to best continue to support the workforce.

The Evaluation Aims and Objectives:

The evaluation will address the following questions:

1. What impact has the program had on capacity to respond to AOD issues at the community level, specifically how has the Program strengthened
    - workforce availability and skills

- access to AOD services for people from remote communities and referral pathways

2. What are the main contributors to program effectiveness and improved access to AOD services for people in remote communities?
3. How effective is the program support unit in providing support that contributes to overall program design, planning, monitoring and reporting?
4. How effective is the model in providing support that contributes to ensuring there is an AOD workforce providing evidence based services for individuals and communities affected by AOD?
5. How successful is the program in ensuring the workforce is supported by evidence based, culturally appropriate practice guides and tools, resources, assessment and supervision tools and client referral pathways
6. How can the program be improved, building on existing strengths and capacity?

A detailed explanation of the methodology and a list of key informants are contained in Appendix 1.

FINDINGS

Investment in Developing an Evidence-based Program and Service Model

In 2006 the Council of Australian Governments (COAG) allocated funding for a remote alcohol and other drugs workforce. Funding was initially allocated for a Program Coordinator, (Jennifer Frendin) who remains as a key staff member of the Program Support Unit (PSU). The Program Coordinator began by setting up a consultation mechanism and a governance working group, visiting communities with DOH, AMSANT and OATSIH representatives to discuss the project with community leaders and investigating the options for establishing data collection and storage systems that could run across government and non government organisations (NGO).

Initially funding was offered to establish and maintain a workforce of nurses. However the Program Coordinator developed a Position Paper, which successfully argued for a shift from the original proposal of employing Registered Nurses (RNs) to one of employing local Indigenous workers(NT Department of Health and Family Services, 2008). The program was then able to recruit, train and support a local workforce of Indigenous people, drawn from their communities.

As evidenced by the documentation contained in the Position Paper (NT Department of Health and Family Services, 2008) and in the Risk Analysis undertaken early in the program's establishment phase (NT DOH, 2007), this approach recognized:

- the need for locally-planned, needs-based service models;
- the importance of holistic, culturally safe care and cognisance of the social determinants of health and wellbeing;
- the value in focusing on health promotion, illness prevention and primary health care;
- the need for a workforce where the skill set meets the needs of the communities ;
- the need to develop a system that supports maximising scopes of practice while ensuring quality and safety for consumers;

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

This approach 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 in comparable countries. However, these themes are not well documented in Australia until several years after the Remote AOD Program was conceptualised and developed. This indicates the value of the investment in consultation and literature reviewing that took place prior to developing the Service Model. It may also indicate that the model has been recognised and promoted as a best practice. For example several years later the 2011 Background Paper informing the development of the Rural and Remote Health Workforce Innovation and Reform Strategy referenced these same elements as best practice.(Siggins Miller, 2011)

In the first year of operations the Program Coordinator promoted the underlying principals of the program (to employ Indigenous people from remote communities as a priority, place the positions within primary health care services while simultaneously providing them with training and support to enable them to perform their roles and further developed the model. The following tasks were undertaken:

- Development of Job Descriptions
- Positions evaluated and approved
- Recruitment processes established and the first few workers were recruited
- Orientation procedures established
- Project risks identified and mitigated (for example concerns over lack of accommodation options for staff)
- Service Partnership Plans were commenced

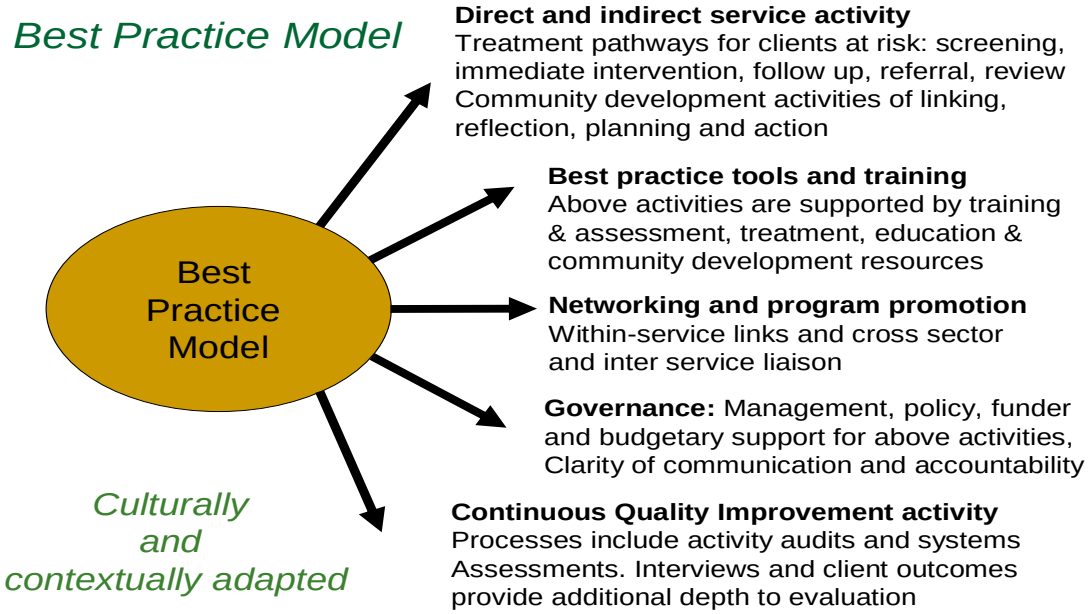
There was an initial investment in developing a model where plans and priorities are developed at the PHCC level … this has resulted in the program objectives being well understood and highly valued across both Government and Aboriginal community controlled health oraanisations

There was an initial investment of extensive consultation and risk analysis, and in developing a model based on best practice and lessons learned from initiatives which preceded the Program, including NT the Living with Alcohol Program, the Aboriginal Mental health Worker Program, The Australian Integrated Mental Health Initiative NT and the Audits of Best Practice in Chronic Disease (ABCD) Program.

Very early in the life of the Program the Coordinator established a working partnership with senior clinicians and experienced researchers with expertise in Aboriginal mental health and substance misuse issues. This partnership has resulted in the development of a service model that draws on current literature and best practice. It also ensures the model continues to evolve and is enriched by the lessons learned from its own evolution and that of other programs. The relationship between the program and external people with expertise is robust and ongoing. There are regular opportunities for the PSU staff to reflect on progress and evolution of the program in consultation with the external experts, who understand the history and challenges of the program in detail.

There was also investment in widespread consultation and developing a model where plans and priorities are developed at the PHCC level. This has resulted in the program objectives being well understood and highly valued across both Government and Aboriginal community controlled health organisations.

A best practice service model was developed in the first 18 months of the Program, with leadership from the Clinical Director and supporting tools and processes were developed. The best practice model is represented below:



Overall the model and the domains it covers 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.

Appropriateness and Effectiveness of the Program Design

For the purposes of this evaluation effectiveness has been assessed in regard to how the hub and spoke model and the efforts of the Program Support Unit contribute to the effectiveness of the Workforce and achieving the program objectives. Consistent with the Program objectives, the Program has established and maintained a Remote AOD Workforce: there are currently 27 workers in 17 remote communities. The program meets the objectives in that the remote workers are:

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

- based within primary health care services located in remote communities with significant alcohol and other drug issues
- providing a service to people that previously had limited access to AOD services
- culturally appropriate (the workers are predominantly Indigenous themselves and are guided by the community development and cultural safety frameworks and the work of those based in AMS is overseen by local Health Boards made up of Indigenous people)
- evidence based – evidence is sourced and brokered by the PSU as well as by some of the workers, and it informs the training, supervision and mentoring provided by the PSU

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

Good governance

The PSU, in consultation with OATSIH, the PHCC managers, AMSANT and other stakeholders, 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. A Working Group (which includes the external experts engaged by the Program Coordinator to advise on evidence and best practice) provides input and feedback in addition to that provided by the DOH Director of Remote Health. 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 Program Coordinator established the Working Group with broad stakeholder representation during the establishment stage of the program. The Working Group provided input into development of the Governance Framework, which is documented and has been widely distributed.

There are numerous systems that contribute to the good governance of the program. Responsibilities are clear and accountability mechanisms are varied and well established.

In the past the Working Group has acted to promote alignment between the Remote AOD workforce, the DOH Alcohol & Other Drugs Program and AMSANT (AMSANT represents the priorities and concerns of the Aboriginal Community Controlled Health Organisations.

The Working Group operated for approximately 3.5 years, and has recently been reinstated after a hiatus of about 2 years.

Program performance is monitored and the PSU provides quarterly reports to OATSIH against the annual Action Plan.

In order to promote effectiveness and compliance with good practice, the evaluation found that expectations and guidelines are clearly articulated and documented through:

- A shared value system (generated by the workforce during the bi-annual forums)
- A range of unique, culturally appropriate and evidence based assessment guides and tools for workers that are informed by research such as base of AIMhi NT and the ABCD CQI processes developed within the NT.
- A clinical Governance Framework

There is documentation[1] that supports the PSU claims that guidelines are developed by qualified and experienced staff or consultants in consultation with the workers, the Working Group and other stakeholders. All the workers that participated in the evaluation can give numerous examples of issues that have been raised with them by the PSU, the opportunities they have had to provide input into decision making, reporting to the funder and developing governance documents such as the clinical Governance Framework, the Community Development Framework and the model of client care.

[1] Documentation exists in the form of discussion papers, distribution lists for consultations, written feedback and notes from meetings and reports such as the Action Plan Reporting Forms

For example several of the workers that have been with the program a long time could recall being consulted during the development of a Best Practice Pathway for one-on one service delivery. As described by one informant, the Pathway includes *"stuff about when to do an assessment, referral, intervention, provide or link to follow up treatment, review and prompts them to provide feedback to other services working with the same client. I look at it to remind me sometimes before supervision or to tell a new worker about it".*

There have been no reported or rumoured instances of poor governance, misuse of program assets, misappropriation of funds or poor decision making that has resulted in risk for the program or the Workforce.

Robust, systematic communication, support and assistance in areas related to AOD

The governance systems for the program include regular communication between the PSU and the managers of the PHCC. The success of the program is largely due to the robust, systematic communication, support and assistance provided by the PSU. There are many channels of both formal and informal communication that are well embedded in the daily management of the program. Channels of communication include fortnightly teleconferences, monthly data, twice yearly forums, and regular consistent face to face and telephone contact, client review discussions, provision of support materials and training, as well as clinical supervision. The communication channels facilitate regular sharing and communication between the PSU and the workers, as well as communication directly between workers.

The AOD workers and the PHCC managers report that engagement with the Program Support Unit is multi-faceted, consistent and regular and the workforce is appreciative of the support from the PSU. One worker said *"talking to them regularly makes a big difference, without that we don't feel we'd have the full on support that we want."*

The fortnightly teleconferences are hosted by the PSU, and regardless of other commitments the teleconferences are held consistently and on schedule. Participation rates are high and all workers report that they organise their commitments so as to enable them to participate as fully and often as possible. No one reported feeling any dissatisfaction with the fortnightly teleconferences, and most workers participating in the evaluation regarded the teleconferences as a consistent, useful and welcome form of support.

For example during a group discussion conducted as part of the evaluation the workers recalled a session from a previous forum when Jonathan Hermawan Tjapaltjarri (Fire and Water Consultancies) did a session on motivation/ motivational speaking/ how to engage young people. One of the workers said *"AOD workers find it hard to motivate youth, to engage them"*. They were asked "did the motivational talk help you?" A female AOD worker replied *"Yes, he gave us some slides from his talk. I thought to myself, 'I could actually do this'.* Another worker said *"He reinforces what we do, he motivates us".*

Many remote AOD workers participating in the evaluation provided examples of how they benefit from the robust and consistent communication and support from the PCSU. Communications were described as 'warm' and 'respectful', and the PSU staff are regarded by the AOD workers interviewed for the evaluation as exceeding expectations. One worker provided the following written feedback about a Forum held in February 2011:

"It has been a very busy month for the AOD work unit with the Forum, client no's increasing, community engagement, and service visits etc. The Remote AOD Forum was excellent, particularly the presentations/training from Dr Trish and Fiona Leibrick. Great value." (Jackson, Arnold, & Rogers, Feb 2011).

During the teleconferences the PSU communicate about any upcoming program wide activities, relevant feedback from the Working Group and other stakeholders, new resources and training opportunities. The workers are encouraged to talk about what they have tried, what works, issues they are dealing with and anything that affects the social, emotional and physical health of their community and impacts on their work, including suicides, significant conflicts, festivals etc.

At the twice yearly face to face forums the workers come together and are provided with information and participate in team building activities. Workers give their own presentations to report on what they have been doing and reflect on their success and challenges. Team building activities that foster a sense of belonging and build trust among the workers and the PSU staff are incorporated into the forums. A diverse range of external people are invited to come and share information on issues such as contemporary drug and alcohol issues and education, the roll out of OPAL fuel, brief interventions, etc. Each forum provides an opportunity for the workers to have input into resources that are being developed by the PSU and provides an avenue for external agencies to also present and gain feedback about their resources and planned activities.

The forums last 3 days and are consultative and mostly interactive, although at the Forum attended as part of the evaluation there were two speakers that spoke at length and the level of interaction was limited. These were guest speakers, not regular participants. Most participants are actively engaged in discussion during the Forums and plenty of time is allowed for informal get togethers and socialising. Topics scheduled for discussion are drawn from the priorities set by the workers and new evidence and policy developments. The Agendas are always negotiated and communicated prior to the Forums. The Agenda is flexible; however it does not change repeatedly or at the last minute. The workers know what to expect and the PSU staff running the Forums appear well organised and relaxed. This creates a low stress, relaxed atmosphere for everyone which is conducive to learning. The level of participation I the Forum held during the evaluation was very high.

One or two of the workers reported difficulty with travelling to the forums – either because they don't like travelling/flying off their own country or they find the experience of being in a foreign environment a bit overwhelming. Both of these workers indicated that despite their dislike of travelling they make an effort to attend the forums regularly because they know *'it will be good'*.

AOD workers are able to describe how the Program Coordinator, along with the Clinical Supervisor and the Education, Training & Clinical Program Officer have all visited their PHCC to make sure, even in times of high staff turnover, that the managers understand the role of the AOD workers, the emphasis placed on working within a primary health care team, the resources developed by and available to the program and support and supervision provided by the PSU.

The PSU solicits feedback from the PHCC Managers and other staff that work with AOD workers to see how the workers are perceived, valued and supported on their communities. Most feedback is anecdotal. It is gained largely through community visits. The workers themselves give verbal feedback but so do their managers, coordinators, public health managers, co-workers, even sometimes clients will share something. There is a consistent message that workers feel valued and supported.

The PSU is regarded as critical in providing support that contributes to ensuring the workforce has a good understanding of health, medical and social issues related to AOD. During the evaluation AOD workers were asked to recall any training or information they had received from the PSU related to AOD. The range of responses includes:

- Definitions of terms like 'hazardous use', 'substance abuse', 'harmful use' etc
- How different drugs are used, their effect and what they do to different parts of the body including the brain and the heart
- How to do a Strengths based assessment and intervention (see the strengths first, worries after)
- Alcohol Management Plans and other Government policies
- Patient Assistance Travel Scheme for AOD clients

The technical support[2] is underpinned by a robust, open and systematic communication system led by the PSU. One way this occurs is through the development of resources, such as 'Yarning About Alcohol' and 'Yarning About Gunga' . All resources created by the PSU are developed in collaboration with the Workforce and ample time and opportunity is provided for the workers to make comment during the development of the resources.

[2]Technical assistance refers to the provision of information, training and evidence specific to the health, medical and social aspects of AOD for example information about how alcohol damages the brain, polydrug use, coexisting mental health problems or the steps involved in detoxification. This is considered technical support as opposed to human resources support or administrative support.

The workers report that the PSU has facilitated them to develop relationships with one another that have allowed them to share information between individual workers across communities. The concept of sharing information is now well established and the workers expect to do this both formally and informally. For example, after attending a Cannabis Train the Trainer workshop one of the workers indicated in his regular Workers Monthly Data "As discussed, I would like to share the material from the Cannabis train the trainer workshop with others in the Remote AOD group." (Clottu, Feb 2011)

Technical support is provided through access to evidence based guidelines, often developed specifically for the workforce, with their context and resources constraints and practice limitations in mind. This is much appreciated by the Workforce. Technical support is also evidence in the exchange of research findings and the provision of regular training and tips.

Regular external clinical supervision

All remote AOD workers receive monthly clinical supervision. There is widespread appreciation of supervision among the workforce, and no-one complained they were receiving too much or too little supervision. Clinical supervision ensures that workers are operating within the scope of their professional practice and the level they are working at. A culture of supervision is becoming well established and the scope is broad and tailored to the needs of the worker. Supervision is supported by the Yarning About Work tool developed by and for the Program.

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 and discuss specific clients' issues
- Fresh ideas and information on areas such as problem solving, community engagement, reaching people with acute and chronic AOD issues, supporting the community when suicides occur, etc
- Time to talk about all the different things covered in the Yarning About Work tool, for example: ethical worries, boundaries training and education, home culture clashing with work culture, successes and challenges, time management, communication etc as well as making time to reflect on what keeps workers strong, and think through what I need to work on
- A safe space where they can explore and express their feelings about the work, the people they work with and the systems they work within (including excitement, frustration, anxiety, despair etc)

- Objective feedback and guidance related to work issues and decisions from someone with positive regard for them and an understanding of their role in the community and the PHCC (especially where they had received abuse or criticism from clients or people with AOD issues, jealousy from other community members, payback after trying to mediate conflict resolution etc)
- Encouragement to identify and plan for self-care, debriefing, regular breaks etc
- A forum where they can develop professional skills (e.g. time management, problem-solving, managing relationships with others, avoiding procrastination, doing plans on paper, advocating for their program within the PHCC etc)

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. Others raised the value of supervision in helping them to deal with accumulated stress, 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. This is a good indication of the high level of trust the workers have in one another and the facilitation of the PSU.

Developing a Workforce with a Professional Identity and Clear Role

A major contributor to program effectiveness lies in the way the program has developed a sense of professional identity among the workers and defined and maintained a clear role for the workers across all the organisations in which they work. The PSU has developed clear job roles and a sense of a professional identity among the workforce that ensures that despite the workers operating in a range of contexts and under a variety of arrangements within primary health care, there is consistency and the roles are well understood and valued.

During the evaluation the RAOD 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. This is underpinned by explicit shared values which the workers articulated at the May and November 2012 forums.

This respect and recognition of the AOD workers as health professionals has been achieved despite many of the workers having had very little formal health qualifications prior to taking up their roles. The workers are supported to increase their expertise and range of skills as they become more deeply involved in the work. All workers must have a minimum Cert III in Community Services or be working towards its completion. There are detailed records of training that the workers have received from both within the Workforce and by external providers. In addition to formal training, topics of interest are covered during fortnightly teleconferences.

Training has resulted in a workforce that is both well grounded in evidence based practice and willing to take risks to achieve successful innovations. 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.

Training needs analyses are conducted by the Clinical Supervisor & Education, Training & Clinical Program Officer as well as by the PHCC managers in consultation with the workers, Additional training and education topics are identified during supervision and other discussions held between the workers and the PSU staff. This has resulted in a workforce that is both well grounded in evidence based practice and willing to take risks to achieve successful innovations. 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.

Although some AOD workers are working closely with Social and Emotional Wellbeing (SEWB) teams that integrate mental health and AOD work, there was no evidence of the members of the partnership 'pulling in different directions', and significant evidence of mutual respect, appreciation and cooperation. For example, one SEWB team leader stated that the rest of the SEWB team did not require support from the PSU, because their AMS was able to provide for all their training and support needs, however there was no suggestion that the participation of the AOD worker in the partnership was in any way problematic. The AMS was able to accommodate participation in the partnership along with integration of the AOD worker in a PHCC which also includes and supports a SEWB team.

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. Workers are aware that in order to engage successfully with individuals, families and communities suffering as result of alcohol and other drug issues they must be prepared to risk further grief, be humbugged and speak out even when this may provoke negative feedback. Feedback from the SEWB team leaders supports this.

Several informants mentioned the stability of the workforce as one of its strengths. For example one worker said *"we get to know each other at the Forums, and we know we can get it all off our chest with one of the other workers when we all get together."* The workers (past and current) report that retention is high because the community and the primary health care centres value the workers and the workers value the support and training they receive from the PSU and their SEWB teams and PHCC managers. The sense of belonging, regular clinical supervision and many opportunities to communicate, debrief, share their successes and failures are cited as reasons why the workers feel happy in their jobs.

Effectiveness of PSU support for planning, monitoring and reporting

This model and the support from the PSU allows for plans and priorities to be developed at the community and health service level, while activity reports are aggregated and reported by the PSU to OATSIH. The model encourages AOD workers to draw on both traditional Aboriginal and non-Indigenous ways of planning, gathering information, reflecting and networking. This has resulted in the program objectives being well understood and highly valued across both Government and AMS AOD workers as evidenced by feedback from PHCC Managers, AOD workers and their co –workers both during the evaluation and in correspondence and meeting minutes held by the PSU.

The PSU submits an Action Plan in July each year to OATSIH, outlining specific objectives and strategies that will be implemented to increase capacity for service provision at the local level, and enable the remote AOD workforce to provide appropriate support for clients, carers, families and communities affected by AOD. The PSU completes a quarterly report documenting activities.

The hub and spoke, partnership based model appears to meting the needs and expectations of the partners, and providing consistent and relevant support to the Workforce.

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. All the workers are able to articulate what their overall plans are for the year/funding period. During observation of the workforce as they participated in a Forum (Alice Springs, November 2012) and while they were doing their work it was clear that many of the AOD workers demonstrated both an understanding of planning and an outcome focus – that is they talked about assisting individuals and families to change AOD related behaviour and strategies for coping with substance misuse. All the workers demonstrated during interviews for the evaluation that they are thinking about how their work contributes to changes in outcomes.

An example of how the program support unit provides effective support that contributes to reporting is evidenced by discussion by several of the workers of participation in the 2012 National Cannabis Conference. During the evaluation the workers participating in the Forum in Alice Springs in November 2012 were shown a number of photographs and asked to provide the back story to the picture. When shown a picture taken at the conference one participant explained that “We (the AOD remote staff) put some resources together with help from Lauren to present at the conference”. (Male 4) Another went on to say “we presented our model of how we work, and talked about how we help people on the communities to cope.” (Male 2) Another said “The presentation went really well, we nominated two people to speak and the others just attended to support them, to give them moral support.” (Male 5)

Impact of the Program on Capacity to Respond to AOD Issues at the Community Level

Improving access to AOD services

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 and otherwise would have 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. The model of regular reflection on practice ensures that people work within the scope of their practice, have the confidence to take calculated risks and learn from their efforts.

All Remote AOD workers can articulate how their role contributes to achieving greater access to services for Aboriginal people in remote areas. They can cite examples of referral pathways they have developed, and the creative mechanisms they have used to expand their knowledge of the services available and link their clients to these services. The can also provide examples of how the referral pathways are increasing access to services. For example a worker from Borroloola Health Centre reported:

I recently referred a client to BRAADAG and they received great service. Staff friendly and supportive and feedback from our client is that she is doing well, has caught up with some family members and she is planning on doing some computer training in Tennant Creek. 28TH February - Mother and child doing well. The Client has spoken with family members in Borroloola by phone and today I had three referrals from other members of the community – young women with babies who also want to go to BRAADAG. (Corpus, Feb 2011)

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. Some workers are partnering with other program areas, including SEWB programs, shire councils, sport and recreation officers etc to fund diversionary activities, culture camps and other means of addressing AOD issues. It may be beneficial to provide training on how to leverage funds and resources. (See Recommendations)

Many of the PHCC operating in communities or small townships are perceived as operating primarily as acute care services and some of the AOD workers report that they are one of very few people doing preventive and/or primary health care outside the clinic. The addition of an AOD worker provides an opportunity to bring a broader primary health care focus to the work, including components such as prevention, outreach and community development which may otherwise be missing from or limited within the PHCC.

Program Impact

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.

For example, one worker told the following story that demonstrates significant change as a result of having a culturally appropriate, local AOD worker:

When I started in this role a few years ago I saw people from my community overcome with a sense of despair and hopelessness. When I talked to them during my regular outreach and walks around the community they could talk of change in only two ways – that is, nothing ever changes, or things are changing for the worse. They thought that tomorrow would look and feel exactly like today, maybe worse. I could see how this played out – they feel hopeless, so they don't want to feel anything, so they drink. The highs come from winning a game of cards; the excitement comes from fights and drama.

I have been trying to give people a reason to feel something good. So I tried to introduce them to the feeling of optimism that comes with planning and looking forward to something – at first planning small day trips, doing relatively familiar things, hunting and fishing trips, gradually going to locations a bit further away, places they remember from their childhood, places that hold positive memories for them. I didn't plan that, but when we got to places and the good memories started to come out I could see it made a difference, it helped them feel good about today and about the past. It gave them a chance to create new, happy memories.

It is much easier now for them to support each other to drink less, fight less, do more for each other and themselves. It takes a long time, and you have to be there everyday to foster and reinforce these new feelings, but its working.

The remote AOD Workers identify themselves as having a role in enabling and facilitating, and clearly articulate that they have no intention of claiming success from the people they reach through their work (the person, family or community).

The program shows a range of signs of having a positive impact on a range of beneficiaries, and contributing to reducing alcohol and other drug related harm at the community and family level. Although it is difficult to attribute specific achievements to what is essentially one component of a broader prevention and service response system, the program can clearly be demonstrated to have had an impact on:

- the delivery of AOD services through primary health care centres
- capacity to respond to AOD issues at the community level and through newly developed referral pathways
- workforce availability and skills in remote areas
- increased access to AOD services for people from remote communities

The health workforce in remote areas benefits from access to the AOD workers - health professionals screen for AOD because they have someone to refer new cases to case finding increased, reduced loss to follow up, tools that make it easy for them to assess, case manage and refer people with AOD issues.

People living with AOD issues and their families and immediate communities benefit from a skilled local workforce in that families and individuals can assess culturally appropriate screening, case management and prevention interventions. For example in some communities the AOD workers are targeting young people or homeless people with diversionary activities that take their mind off their problems, model healthy problem solving and help them to develop life skills.

The program beneficiaries are expanding to include the wider AOD sector and the remote Health sector because resources developed for/by the program, including the governance framework; assessment tools and case planning tools have been adopted and are being used beyond the program. The clinical governance framework, the community development framework and supervision tools are being promoted and extended beyond the remote AOD Workforce into Indigenous health across the NT.

By employing and resourcing local people, community members are provided with role models, and have the opportunity to see Aboriginal people taking on valued professional role. It also has the benefit. In addition the PHCC can be viewed as inclusive because they have local people as staff members, and by training local people, the entire community benefits and is invested in the success of that program. There are instances where a worker has decided to resign from the AOD worker position, only to encourage his son to be the next remote AOD worker. The impact goes beyond just client service delivery; it extends to empowering local people to work in their own community.

There is documentation that supports the PCSU claims that guidelines and best practice based tools are developed by qualified and experienced staff or consultants in consultation with the partnership members and other stakeholders.

The majority of 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. The process of developing the materials was said to be appropriately long and inclusive, to allow for plenty of feedback and input. The resources were not specifically evaluated, however they constitute a significant component of the support provided by the PSU, so feedback on the impact of having the resources developed by and for the remote AOD Workforce was covered in key informant interviews and discussions during the forum held in Alice Springs. The resources are seen as particularly important in the context of the limited number of culturally appropriate mental health- and AOD resources available. The culturally appropriate AIMhi mental health resources have provided inspiration in this regard. Respondents agreed the materials are suitable because they are short, accurate and relevant, and incorporate vocabulary and pictures appropriate for the audience. AOD workers prioritise story telling over written communication in their interaction with clients and families and the visual aids are used to support this process.

There are no specific outcomes or impact indicators included in the program framework, however many of the remote AOD workers are able to articulate how they gauge whether or not they are effective. For example:

At the Santa Teresa Health centre run by the Mpwelarre Health Aboriginal Corporation, Central Australian Aboriginal Congress, the AOD worker is part of the Social and Emotional Wellbeing team. The SEWB works with others in the community, notably Bush Mob and the local stockmen to encourage young men with a history of drinking or drugs to get involved with learning horse handling skills. They run an annual five day horse culture trek in the desert with the Stockmen as the guides and mentors. The trek is made in Central Australia by, and for, young people to get the self-respect, trust and courage and skill to have a good life because the community believes that grog, sniffing, drugs and crime are no good.

The AOD worker describes how he is able to gauge whether or not the program has had an impact on young men by observing how they interact with their horse. He says *"if a young fella can't manage himself he can't manage a horse. To calm the horse and demonstrate that he is in control he must be able to calm himself down, regulate his emotions. He must be in control of himself or he cannot control a horse. If we have given him enough support, if he has spent enough time listening to the old stock men, he will have developed himself so he can handle himself and the horse."*

Another AOD worker from Anyinginyi Health Aboriginal Corporation works as part of a SEWB team. The AOD workers work alongside community support workers in a men's centre in town. He talks about the way participation in the program reduces alcohol related harm:

> *When the clients first come in they are usually quiet and shy, but after a while you notice that they are getting up, joining in and talking, opening up. I can see the satisfaction on their face when they come in to the centre in the morning after they have had a hard night, maybe drinking, being in a house that's over crowded, not sleeping, but when they walk in here they know it's safe place, so you can achieve things with them.*
>
> *Once they start to get involved in the groups the men will talk about cultural stuff, about things they are going through in their life, for example there could be 10 people in the house, lots of drinking going on etc but they are trying to get away from it. If they live with these things day in and day out they may get depressed, they wake up expecting to face the same things every day, they are putting sandbags on their shoulders and taking the weight of it all, they bottle it up, all the thoughts and emotions build up and then they explode at the end of the week when they have a drink.*
>
> *If they can come in here, if they can do something positive, get away from the drinking and the drama and the trouble, then they can talk about the things happening in their life, share it. Their life changes and they don't wake up expecting the same drinking and trouble every day. Even if they have a drink, they are not going to explode, because they are not carrying that load. The men don't walk around with those sandbags on their shoulders and they can have a drink without exploding, so everyone benefits from that. Our work is having an impact.*

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.

The model contributes to ensuring the remote AOD workforce is providing services that are culturally appropriate, locally initiated and supported and therefore sustainable.

How can the program be improved, building on existing practice and capacity?

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. Although one SEWB team leader stated that the rest of the SEWB team did not require support from the PSU, there was no suggestion that the participation of the AOD worker in the partnership was in any way problematic. The AMS was able to accommodate participation in the partnership along with integration of the AOD worker in a PHCC which also includes and supports a SEWB team. The model has achieved the objectives of establishing a sustainable, culturally appropriate Remote AOD Workforce which is based within primary health care services.

In terms of continuing to strengthen the forums the evaluation finds that the forums could evolve to include:

- Providing an opportunity for men and women to meet separately to discuss and reflect on their work and their own strengths and weaknesses
- Continuing to explore opportunities to hold forums in a diverse range of locations such as the proposed forum in Jabiru in May 2013. This will allow those who find it unappealing to travel to the bigger regional centres to participate comfortably.
- Ensuring that guest speakers are encouraged to present their information in a format that is appropriate for people with a limited tolerance for sitting through lectures and one way communication.
- The forums could provide additional opportunities that allow people to reflect on and share their motivations, challenges, lessons learned through interactive and activities, and in a way that allows the PSU to document, promote and celebrate Lessons Learned.
- The forums could include opportunities to discuss some of the issues that have come up in supervision so workers can review their practice, learn from each others reflective practice and have key lessons reinforced. The following topics could be covered: managing relationships with others, leveraging support from potential partners, addressing intergenerational trauma that contributes to AOD problems, how men and women experience stress etc.
- The forums could include opportunities more space for workers to talk and debrief in groups (men and women separate groups for some but not all the time) during the forum/team building day.

Overall the program is effective and the model appears to be robust, meeting the needs of the partnership members and achieving the program objectives. No major changes are recommended.

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 among the Working Group of some outcome indicators or measures of success for the Program. In part the difficulty of assessing impact relates to the absence of a written program logic with a focus on client and community outcomes. The current program objectives relate to establishing, supporting and maintaining an appropriate workforce. However, now that the program has been operating for five years it may be timely to capitalise on the stability of the workforce, the expertise and experience that has been developed and the community development and Continuous Quality Improvement frameworks that have recently been developed and think more about impacts and the outcomes the program contributes to.

A program logic [3]could assist the program to identify the outcomes the workforce could feasibly contribute to achieving for individuals and communities, and provide an opportunity for the program to articulate a Theory of Change. Drawing up a Program Logic also provides an opportunity for the Program to articulate assumptions related to the inputs being provided and the changes they are expected to result in.

[3]A program logic (also known as outcome model, outcome logic, logic model, or outcome hierarchy) sets out what a project will do and how it will do it. Program logics uses diagrams or other methods to set out the steps which occur in a program leading from inputs, through activities right up to high-level outcomes. The program logic does this by visually representing a linear sequence of steps that need to occur for a project to meet its desired outcomes. This generally consists of identifying the inputs, activities, outputs, and outcomes (from immediate, to long term). An important component of program logics is the identification of *assumptions* that link steps and underpin the strategies that have been adopted to meet the program objectives.

Appendix 1 Methodology and Timeline:

The evaluation will utilise key aspects of an Appreciative Enquiry approach to identify the successful elements of the program and make recommendations about how to continue to improve the program model. Appreciative Inquiry (AI) is a positive, strengths-based approach to systematic discovery of what contributes to making a system (i.e. in this case a hub and spoke remote AOD Workforce program model) most alive and effective. Instead of focusing on what's wrong and how to fix it AI looks for and builds on strengths and emphasizes the importance of local knowledge. The "appreciating" component of the AI method is described as the art and practice of asking questions that can help to identify, anticipate, affirm and build on the strengths of the model. AI assumes there are many untapped and rich and inspiring accounts of the positive. (Cooperrider & Srivastva, 1987)

The "inquiring" component involves asking questions to affirm, explore discover and build on new possibilities that can strengthen the model. Appreciating and inquiring are integrated in a variety of ways, including through structured conversations known as "appreciative interviews." These are opportunities for people to tell stories about past high point experiences at work and their dreams for how the model, their work and the program can continue. They provide rich data for analysis throughout the rest of the inquiry. (Cooperrider, Whitney, & Stavros, 2008) Using AI the evaluator will facilitate the participants to "**discover"** the current and past strengths of the model.

The evaluation will be conducted by The Menzies School of Health Research. The evaluation will be led by Ms Jenne Roberts, who will be responsible for facilitating the process and documenting the final report and recommendations and data management and analysis support will be provided by Felicity Ward (Senior Research Assistant).

Data Collection

The evaluation will drawn 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.

Step 1: A Document Review will be conducted to gain insight into the program background, goals and objectives, activities and achievements. This will include documents provided voluntarily by the CSU and relevant ACCHO, reports from the twice yearly staff forums, resources produced and/or used by the program, action plans, meeting minutes, posters, promotional fliers, paintings and photos, spreadsheets, field notes, planning documents and reports provided to OATSIH by the PCSU, etc

Step 2: The Evaluators will design interview guides and data collection story telling activities adapted from relevant good practice guidelines and based on the evaluation questions. Information from the document review and briefings with PCSU staff will be utilised to guide development of the data collection tools. Data will be collected related to the evaluation questions.

Step 3: A key informants list and data collection schedule will be developed in consultation with the PCSU and workforce, the relevant ACCHO and the NT Department of Health.

Step 4: Key informants will be asked to participate in the evaluation, either through one to one or small group conversations or by demonstrating and discussing aspects of the program during site visits (to be approved beforehand by the remote AOD worker and their PHCC Manager, and the NT DOH or ACCHO). Key Informant Interviews will take place (by phone or in person) with the workers, PHC and PCSU staff and other stakeholders using the interview guides.

Step 5: Small and large group discussions will be held during the Remote Alcohol and Other Drugs (AOD) Workforce Forum in Alice Springs in November. Participants at the Forum will be invited to participate in an appreciative inquiry workshop to create a clear image of the programs strengths, achievements and assets that can be built on and guide the future direction of the program and the PCSU. Participation will be voluntary and restricted to only AOD Remote Workforce Program staff.

All data information provided during interviews will be kept confidential unless the informant has given specific and written permission to be quoted. Feedback and information will be attributed where necessary to category of informant – for example, by internal or external stakeholder, program staff PHCC staff etc. These data collection activities may take place concurrently, or in an order than that that specified above.

Data Analysis and Interpretation

The data gathered through all avenues will be weighted and analysed to inform the answers to the specific evaluation questions and to the broader question of the extent to which a Remote AOD Workforce has increased capacity and enabled appropriate support for individuals and communities affected by AOD.

Draft findings and some proposed recommendations will be prepared by the evaluator following an initial analysis of the qualitative data from the document review and interview transcripts, observation field notes etc. These will then be subject to discussion and comment from the AOD PSU staff and selected members of the Working Group. The data will be categorised into recurrent themes and topics that seem relevant to answer the evaluation questions and to develop new insights. Particular attention will be paid to exploring the information, ideas, opinions and attitudes which can help answer the question *how can the program be improved, building on existing strengths and capacity?* Participatory approaches are useful in programs where the implantation environments and approaches vary widely in order to meet the unique and specific needs of a local community. This approach ensures that potential differences in perceptions and priorities based on gender, region, resourcing level etc can be negotiated among the program staff rather than imposed.

Feedback from the PSU staff will be used to strengthen the evaluation's usefulness, set priorities for innovations (change), seek and contextualise information, draw conclusions and to provide an explanation of why some aspects of the program may be more or less successful, relevant or necessary.

Reporting Findings

All information provided will be held in confidence by the evaluator. There may, however, be some cases when identification of the **type** of respondent is deemed necessary, to provide insight into the range of perceptions held or enforce the credibility of an assertion. Individuals and their responses will not be publicly identified in any report, unless their input comes from written reports which are already widely available, not during feedback sessions with client or in any public forum. Anonymity will be guaranteed and the client is requested not to ask the evaluator to identify specific informants.

An evaluation report with recommendations for strengthening a sustainable model of service delivery and maintaining an effective Remote AOD Workforce will be provided directly and in confidence to the client. Any decisions about distribution of findings and the report other interested parties, the public or the workforce will be at the discretion of the client. Jenne Roberts is the sole author of the report, and the report may not be altered in any way by anyone other than the author.

Appendix 2: Timeline

Key Milestones	Date of Completion
Agree to contract, deliverables and approach. Documents provided by AOD Workforce Support Unit and reviewed by Menzies	August 2012
Introduce the evaluation to all AOD Remote Workforce Program staff and other stakeholders, ensure potential participants understand participation is voluntary and document informed consent	September/October 2012
Consensus Meetings between evaluator/s and the AOD Workforce Coordination Unit to finalise specific objectives and evaluation questions, methodology, timeline etc	October 2012
Detailed methodology and timeline for the project, including the schedule for interviews and field visits (to be coordinated by Remote AOD Workforce Coordination Unit)	October 2012
Design or modify Data Collection tools/activities/interview guides to support quantitative and qualitative data collection. Identify key informants (past and present)	October 2012
Undertake data collection, which may include 1) file audit of up to 4 health services 2) focus group discussions being held in Alice Springs in October when the AOD team come together and 3) key informant interviews conducted over the phone and at the 4 sites where file audits are conducted.	November, December 2012
Preliminary Analysis of findings by evaluator, participatory analysis workshop with remote AOD staff (volunteers to be identified during the November Forum)	December 2012
Draft Interim Report including initial findings and draft recommendations, for discussion.	Friday 1st March 2013
Feedback on Draft Findings to Client	6th Feb., & 26th March
Feedback of Draft Findings to AOD workers	May 2013
Final Report with recommendations	15 May 2013

Appendix 3: Key Informants

NAME	ORGANISATION
Barak Sambono	DoH – Daly River
Brian	West Arnhem Shire Council
Bruce Wurrawilya	DoH – Umbakumba
Chris Hawke	Congress – Santa Teresa
Chris Wallace	Congress – Santa Teresa
Claude Poulsen	WAHAC – Hermannsburg
Deb Young	DoH – Borroloola
Fiona Bell	Training, Education & Clinical Program Officer
Greg Sheldon	DoH – Gunbalanya
Jasmine Bald	Former PSU staff
Jennifer Frendin	Remote AOD Workforce Program Coordination
Jill Rogers	Wurli Wurlinjang – Katherine
Joel Stewart	Anyinginyi- Tennant Creek
Joseph Knuth	Danila Dilba – Darwin
Kay Copper	Community and Public Health Programs Manager, Miwatj
Keith Mamarika	DoH – Angurugu
Kupa Teao	Shire Service Manager -Gunbalanya
Lauren Buckley	Remote AOD Program Support & Clinical Supervisor
Meg McLosky	Former AOD Worker (Hermannsburg)
Norman Dulvarie	Miwatj Health - Gove
Patricia Taylor	DoH – Borroloola
Patsy Raymond	Danila Dilba – Darwin
Peter Clottu	Katherine West Health Board- Katherine

Ricky Powell	Anyinginyi Congress- Tennant Creek
Robert Wilson	DoH – Elliott & Ali Curung
Samson Henry	DoH - Jabiru
Sarah Watkins	Wurli Well Being Unit Senior Project Officer
Sarah Haythornthwaite	AMSANT AOD SEWB Workforce Support
Scott Nelson	Wurli Wurlinjang Health Service – Katherine
Dr Tricia Nagel	DOH/Program Mentor
Dr Angela Woltmann	Miwatj Health Service
Dr Jeff Brownscombe	Former Clinical Director
Dr Liz Moore	Public Health Medical Officer AMSANT

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List of Resources

Developed by the Remote Alcohol & Other Drugs Workforce

Works Cited

Name of Resource / Tool	Description	Format	Availability
Assessment 1A	Brief Alcohol & Other Drugs Assessment Tool – culturally appropriate, strengths focused & includes risk check and goal setting.	1 page double-sided A4 (Word)	Available to download and print.
Assessment 1B	Comprehensive Alcohol & Other Drugs Assessment Tool – culturally appropriate, holistic, incorporates pictorial elements, Audit C & goal setting	4 pages double-sided A4 (Word)	Available to download and print.
Brief Wellbeing Screener	Brief Mental Health and self-harm/suicide risk assessment tool. A resource designed to assess mental health issues quickly and easily, questions coming from Menzies School of Health Research's *Yarning about Mental Health.*	1 page double-sided A4 PDF	Available in tear-off pads
Yarning about Alcohol	Strengths based, client focused, culturally appropriate alcohol assessment, Brief Intervention & Motivational Interviewing tool that incorporates Audit C. Developed in collaboration with Menzies School of Health Research.	A5 double-sided brochure folded into thirds. Designed to be written on and kept by client.	Available in tear-off, scored pads of 50.
Yarning about Gunja	Strengths based, client focused, culturally appropriate cannabis assessment, BI & MI tool that incorporates the severity of dependence scale. Developed in collaboration with Menzies School of Health Research.	A5 double-sided brochure folded into thirds. Designed to be written on and kept by client.	Available in tear-off, scored pads of 50.

Yarning about Work	Strengths based, culturally appropriate tool for facilitating the clinical supervision & workforce support for employees. Forms part of the Clinical Supervision Framework developed by the Remote AOD Workforce Support Unit. Designed to explore worker wellbeing and reflection on work in a Strength's based framework.	A5 double-sided brochure folded into thirds. Designed to be written on and kept by the employee.	Available in tear-off, scored pads of 50.
Community Development Framework	Comprehensive resource that addresses culturally appropriate engagement for communities and employees (both Aboriginal & Torres Strait Islander and Non Aboriginal Torres Strait Islander). Discusses cultural security and partnerships and was developed in collaboration with Fire & Water Consultancies.	77 paged document in booklet form.	Available at request through RAODWP Support Unit
Yarning about Remote AOD Work – DVD	This DVD is a brief introduction into being an AOD worker on remote communities in the Northern Territory. Told through the words & experiences of Bruce Wurrawilya, Remote AOD Worker Umbakumba.	DVD – Developed in mid-late 2012 (approximate running time of 15 min)	Available through RAODWP Support Unit
Yarning about Gunja on Groote Eylandt – DVD	This DVD explores the impact of cannabis in the remote communities of Angurugu and Umbakumba on Groote and Bickerton Islands in the Northern Territory. Told through the words & experiences of Bruce Wurrawilya, Remote AOD Worker Umbakumba.	DVD – Developed in mid-late 2012. (approximate running time of 8 min)	Available through RAODWP Support Unit.
Project Plan	Planning tool to assist in the development and implementation of educational or community development activities by employees.	1page double-sided A4 (Word)	Available to download and print.