Providing Alcohol and Other Drug services through Primary Health Care for Aboriginal and Torres Strait Islander people: a toolkit for service planners

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For the Australian National Advisory Council on Alcohol and Drugs (ANACAD)

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Note on this draft

This toolkit consists of eleven stand-alone modules, to allow users to reference and use the parts that are of most use to them. Each module contains descriptions, tools and templates to assist users in developing or extending an integrated care model in their organisation and to suit their local context.

It has been written in a way to support its translation to a web-based resource, i.e. as a set of hierarchically organised pages with no more than around 500 words per page.

CONTENTS

1 About the toolkit

Objective: to provide users with a background to this toolkit, who it is for, how it was developed and how to use it.

This module contains the following sections:

People requiring treatment for alcohol and other drug (AOD) issues commonly have other mental health / social and emotional wellbeing issues and may also suffer from chronic physical health conditions. They may also be facing a range of social challenges such as those related to poverty, poor housing, and lack of access to education. In the Aboriginal context, such clients also frequently bear the effects of intergenerational trauma deriving from the history of colonisation in Australia, and its contemporary expression through racism and social exclusion.

Providing sensitive and effective treatment for clients with such overlapping, complex physical, social and emotional wellbeing needs is a challenge faced by many services. This challenge is compounded by the need to deliver culturally responsive, trauma-informed and healing-focussed care for Aboriginal and Torres Strait Islander people in particular.

In recent years, many health service delivery organisations – especially Aboriginal community controlled health organisations (ACCHOs) – have sought to develop more integrated treatment for their Aboriginal and Torres Strait Islander clients with AOD issues. Such integration, often based upon multidisciplinary practice, seek to deliver improved outcomes for clients based on a more holistic approach to their complex needs.

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled health organisation based in Central Australia. Since 2008, Congress has developed an integrated non-residential treatment model for Aboriginal clients with alcohol and other drug issues, based on three streams of care: social and cultural support; psychological therapy; and medical treatment.

This toolkit is aimed at assisting service planners in other organisations and contexts to adapt and implement similar integrated non-residential treatment model for Aboriginal clients with AOD issues.

The toolkit is flexible and non-prescriptive in its format, supporting a range of pathways to more effective integrated care within the overall evidence-base.

1.1 Who is this toolkit for?

Health service planning aims to improve the health status of a population by the provision of efficient and effective health services, within the constraints of available resources and capacity. Within the Aboriginal and Torres Strait Islander health sector, this function is generally carried out by health service managers, and in ACCHSs with the approval or under the direction of their Boards. In mainstream settings, this is principally the responsibility of senior managers in government, or practice owners / managers in private practice.

Accordingly, the principal target audience for the toolkit is health service managers in primary health care settings making organisational decisions about how to address care provision for Aboriginal clients with AOD issues.

It is recognised that not all health service managers will have AOD / SEWB service delivery experience and that decisions would in these cases be made in consultation with other staff and managers with this experience.

Note that the target audience for this toolkit is therefore not:

- the workforce including clinicians (medical practitioners, psychologists) and social and cultural support workers; or
- Aboriginal and Torres Strait Islander AOD clients themselves.

1.2 How it was developed

This toolkit was developed by Edward Tilton and Lyn Allen, in collaboration with Congress and with funding from the Australian Government Department of Health. It was guided by a Congress Reference Group consisting of:

- Ms Donna Ah Chee (CEO, Congress)
- Dr John Boffa (Chief Medical Officer Public Health, Congress)
- Professor Dennis Gray (National Drug Research Institute)

While this toolkit is based on the Congress model, many other services are on the 'integration journey'. Representatives of a number of other organisations servicing Aboriginal and Torres Strait Islander communities were therefore interviewed during the development of the toolkit to hear from them about *their* experience of integration, to get their views about the challenges they face, the successes they have achieved, and what they thought might be useful to include in the toolkit. These organisations are:

- Aboriginal Medical Services Alliance Northern Territory
- Institute for Urban Indigenous Health
- Mallee District Aboriginal Services
- NTPHN
- South Coast Medical Service Aboriginal Corporation
- Turning Point Eastern Treatment Services
- Victorian Aboriginal Community Controlled Health Organisation
- Wirraka Maya Health Service Aboriginal Corporation

Central Australian Aboriginal Congress and the authors would like to extend their sincere acknowledgement and thanks to these organisations for sharing their diverse experiences,

as well as to the staff at Congress who over many years have worked to develop and implement the model at that organisation.

To support the experience of Congress and other organisations, a desktop scan was undertaken to identify useful material to support or extend implementation. Information from this scan informs much of the toolkit, and links and references are provided throughout to assist users access more detailed information if they need it.

> ***… intensive case management may be necessary for some clients to ensure continuity of social and emotional wellbeing support and advocacy … Logically, such an integrated approach will be delivered by one provider and Aboriginal Community Controlled Health Services are well placed to do so in the communities they serve.***
>
> *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, 2017*

We acknowledge in particular the substantial evidence contained in:

- *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* [1]
- *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field* [2]

1.3 Scope considerations

Toolkit users should consider the following issues related to the scope of the information included in the modules.

This toolkit is based on the experience at Central Australian Aboriginal Congress. Other organisations are on their own 'integration journey' that has evolved from their own experience and in response to the specific needs of the communities they serve. The Congress model itself has been iteratively developed since 2008 and continues to evolve. This toolkit therefore depends heavily on the practical experience of a particular organisation in a particular context in developing an effective and evidence-informed service. As far as possible, within this toolkit the Congress experience has been augmented by evidence of what works for other organisations. The content of the toolbox can be adapted for use in particular local contexts.

In addition:

- **Organisational setting:** following the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* [3], ACCHOs are the logical platform for the delivery of integrated services to Aboriginal and Torres Strait Islander people with AOD issues. The toolkit recognises the particular circumstances of ACCHOs, but has been written in a way that mainstream service providers should also find useful.
- **Scale and geographical context:** Congress is a large, well-established ACCHS which enables it to provide in-house services to support the integrated approach to AOD care: including data management, CQI, HR and finances; a large team of practitioners to deliver those services including the flexibility to cover staff absences; and the capacity to absorb some of the up-front costs associated with

establishing and developing the integrated model. Not all ACCHS or other AOD service providers – especially those in remote areas – will have all these capacities. Toolkit modules contain relevant information that can be adapted regardless of organisation's size or geographical location.

- **Level of detail:** the toolkit identifies key factors that will support developing and implementing an integrated approach to the delivery of AOD services to Aboriginal and Torres Strait Islander people. Many of these issues (such as cultural responsiveness and effective multidisciplinary teams) are not specific to AOD services and are substantial topics in their own right. For these factors, the toolkit modules identify key issues and describe key actions and strategies, and give references and links where toolkit users can find more information.
- **AOD and other SEWB issues:** the focus of this toolkit is those Aboriginal and Torres Strait Islander clients with AOD issues. The essence of Congress' (and other ACCHOs') integrated approach is that all social and emotional wellbeing / mental health issues (including other addictions, such as gambling) are treated in this integrated way. This toolkit provides information that is useful to the delivery of integrated SEWB services more generally.

The toolkit uses Aboriginal and Torres Strait Islander-specific information wherever possible.

1.4 Outline of the toolkit

The toolkit consists of eleven stand-alone modules, to allow readers to reference and use the parts of the kit that are of most use to them. Each module contains descriptions, tools and templates to assist users in developing or extending a care model in their organisation and to suit their local context.

Content is non-prescriptive and designed for flexible implementation, recognising that many ACCHSs and other agencies have already developed their own models of care which they may wish to develop further.

The modules are as follows.

Module	Objective
1. About the toolkit	To provide users with a background to this toolkit, who it is for, how it was developed and how to use it
2. Integrated care for Aboriginal and Torres Strait Islander clients with AOD issues	To provide a background on mental health and social and emotional wellbeing (including AOD issues) in the Aboriginal and Torres Strait Islander context, and the potential role of integrated care in tackling those issues
3. The Congress model of integrated client care	To provide a description of how an integrated 'three streams' of care model for those with AOD issues has been developed and implemented at Central Australian Aboriginal Congress

Module	Objective
4. Cultural responsiveness	To underscore the importance of cultural responsiveness in delivering AOD services for Aboriginal and Torres Strait Islander people
5. Trauma-informed, healing-focused care	To contextualise AOD services for Aboriginal and Torres Strait Islander people in trauma-informed, healing-focused service delivery systems
6. Building and supporting multidisciplinary teams	To enable health service planners/managers to establish and support the multidisciplinary teams that are required to deliver AOD care that is integrated across the three streams of care: medical, therapeutic and social and cultural support
7. Building capacity and competency in the AOD workforce	To enable health service planners/managers to build capacity and competency at the organisational, team and individual level to effectively deliver integrated (3 stream) AOD services
8. Budgeting and financing for integrated AOD care	To identify the costs, savings and potential income sources associated with establishing and delivering integrated AOD care services for Aboriginal and Torres Strait Islander people
9. Information sharing for integrated AOD care	To provide a guide to the sharing of client care information to underpin effective integrated AOD care for Aboriginal and Torres Strait Islander people
10. Physical aspects of effective integrated AOD care	To provide information on co-location and outreach to support effective integrated AOD care for Aboriginal and Torres Strait Islander people
11. Measuring change and reporting service effectiveness	To enable health planners/managers to monitor and assess what changes are occurring as a result of adopting the three streams approach to AOD service delivery

1.5 Definitions

Social and emotional wellbeing:

> *Social and emotional wellbeing is a multifaceted concept. Although the term is often used to describe issues of 'mental health' and 'mental illness', it has a broader scope in that Indigenous culture takes a holistic view of health. It recognises the importance of connection to land, culture, spirituality, ancestry, family and community, how these connections have been shaped across generations, and the processes by which they affect individual wellbeing. It is a whole-of-life view, and it includes the interdependent relationships between families, communities, land, sea and spirit and the cyclical concept of life–death–life. Importantly, these concepts and understandings of maintaining and restoring health and social and emotional wellbeing differ markedly to those in many non-Indigenous-specific (or*

mainstream) programs that tend to emphasise an individual's behavioural and emotional strengths and ability to adapt and cope with the challenges of life [4]

Person-centred care

Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it suits their needs. This means putting people and their families at the centre of decision-making around their treatment and care and seeing them as experts in these areas, working alongside professionals to get the best outcome [3].

Integrated Care

Integrated health services delivery is defined as an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions [5].

Multidisciplinary care

Team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities [6].

For more information

- Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Dudgeon, Milroy, and Walker 2014) is an indispensable reference for any service provider working in this field
- Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field (Skinner, Roche, O'Connor, Pollard, Todd 2005) provides a range of user-friendly and practical tools and resources for supervisors, managers, policy makers and others within the AOD field

2 Integrated care for Aboriginal and Torres Strait Islander clients with AOD issues

Objective: to provide a background on mental health and social and emotional wellbeing (including AOD issues) in the Aboriginal and Torres Strait Islander context, and the potential role of integrated care in tackling those issues.

This module contains the following sections:

Integrated care systems are particularly relevant for Aboriginal and Torres Strait Islander people with AOD issues because of the holistic approach to health in Aboriginal and Torres Strait Islander culture, and the closely associated definition of social and emotional wellbeing which includes family, community, and culture as essential to wellbeing.

In this context, integrated care systems seek to match how they provide services with the client's needs and their experience and understanding of the issues they face. An integrated approach is therefore people-centred, holistic and multi-disciplinary as well as in the Aboriginal and Torres Strait Islander context culturally responsive (see Module 4) and trauma-informed and healing-focused (Module 5).

2.1 Service delivery context

Social and emotional wellbeing (SEWB) is a concept central to Aboriginal and Torres Strait Islander cultures. Unlike conventional non-Indigenous definitions of mental health which focus on individual functioning, social and emotional wellbeing includes an Aboriginal person's connections to their family, community and country as well as cultural practices and spiritual beliefs [4].

However, Aboriginal and Torres Strait Islander social and emotional wellbeing has been profoundly disrupted by the process of colonisation. This has included:

- the suppression of traditional systems of authority and meaning;
- the forcible removal of children from families;
- economic exploitation; and
- discrimination, exclusion and racism.

Despite the resistance and resilience of Aboriginal peoples, this led to communities marked deeply by intergenerational trauma and disadvantage.

As a result, poor mental health and social and emotional wellbeing including high levels of alcohol and other drug (AOD) use and other addictions have become widespread and part of the daily experience of many Aboriginal communities.

For example:

- a third (33%) of Aboriginal and Torres Strait Islander adults report high or very high levels of psychological distress – almost three times the rate as for the non-Indigenous population; and
- 29% report having a long-term mental health condition including depression; anxiety; behavioural or emotional problems; and/or harmful AOD use [7].

> ***Mental distress is a common and crippling problem for many Aboriginal people … [but] culturally appropriate services for Aboriginal people in the mental health area are virtually non-existent.***
>
> *National Aboriginal Health Strategy, 1989*

Against these negative influences of the experience of colonisation must be placed the protective effects of the diverse Aboriginal and Torres Strait Islander cultures which continue to support resilience, positive social and emotional wellbeing, and a life free of addiction to alcohol and other drugs [4].

2.2 The need for integrated care

Substance use disorders, other mental health / social and emotional wellbeing issues, and medical conditions particularly chronic diseases tend to cluster in individuals and communities along with other markers of social, economic and intergenerational disadvantage. This is particularly the case in Aboriginal and Torres Strait Islander Australia [8].

Those with such co-morbidities have poorer outcomes from treatment, because:

- the overlapping complexity of these issues forms a challenge to treatment in itself; and
- the multiple disadvantages (poverty, intergenerational disadvantage) that such clients are likely to carry reduces their capacity to engage consistently and meaningfully in treatment.

> ***Given the high levels of background stress, substance misuse also figures prominently as a background factor to mental illness.***
>
> Dudgeon et al Working Together 2014 Ch2 page 30

A major contributing factor is also that care for clients' AOD, mental health, and other chronic health problems is commonly provided in separate, disconnected treatment systems.

The provision of poorly integrated services in 'silos' places the responsibility for managing multiple services and treatment streams largely upon the client, yet often it is those clients with multiple complex needs who are least able to successfully and consistently do so. In addition, stigma associated with access to specific identified AOD /mental health is a barrier to help seeking.

In response to such systemic factors, non-stigmatising, integrated approaches have been developed to better meet the needs of clients with complex overlapping social and emotional wellbeing and physical conditions. While evidence from Aboriginal Australia is limited, in other contexts clients receiving integrated treatment have been shown to have improved outcomes [9-11].

2.3 What is integrated care?

There is no universal definition or agreed understanding of the concept of integration of care to meet the holistic needs of clients with multiple overlapping mental health, social and emotional wellbeing and physical health needs [12].

Different services in different places at different times have developed their own definitions and models of integrated care. Much of the discussion is about integration between different organisations, rather than within a single organisation. However, the key features of integrated care include that it:

- is **people-centred**, focusing on the needs of individuals, their families and communities;
- seeks to address a person's **holistic** needs, including physical and mental health and social and emotional wellbeing; and
- involves a **multidisciplinary** approach, seamlessly coordinating care for the client across multiple providers and in multiple settings.

A number of common features of successful integrated care models, include:

1. *funding models* that recognise and support integrated care;
2. *a focus on team functioning and organisational culture*, that includes clarity of roles between practitioners, overcoming professional boundaries, reducing status and power differentials between professions, and promoting organisational cultures that value continuous learning, teamwork and innovation;
3. *training* to foster team work and support integrated working,
4. *case management* approaches to plan and arrange care for the client and ensure their needs are being met;
5. *co-location of services* to facilitate referrals and increase primary care providers' screening for AOD and other behavioural issues; and
6. *addressing information sharing / confidentiality issues*, including use of IT systems and routine obtaining of informed consent from clients.

> ***Integrated health services delivery is defined as an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions.***
>
> World Health Organization

To these issues identified in a range of non-Aboriginal contexts must be added as a critical factor in the success of service delivery in Aboriginal Australia:

7. *prioritising working across Aboriginal and non-Aboriginal cultures,* noting that Aboriginal organisations' delivery of health services is qualitatively different to their delivery by non-Indigenous health organisations, that cultural factors must be recognised in planning and delivery, and that evidence-based approaches need to be adapted to fit the local Aboriginal context.

> ***Aboriginal and Torres Strait Islander people prefer to take a holistic view of mental health [which] incorporates the physical, social, emotional, and cultural wellbeing of individuals and their communities. …***
>
> Dudgeon 2014 page xxv

Integrated care is ideally delivered in a single organisation, with common policies, practices, information systems, finances etc. However, in many places especially remote areas, organisations may not be able to provide a full suite of integrated services themselves, and therefore the establishment of robust, formalised partnerships between organisations is critical.

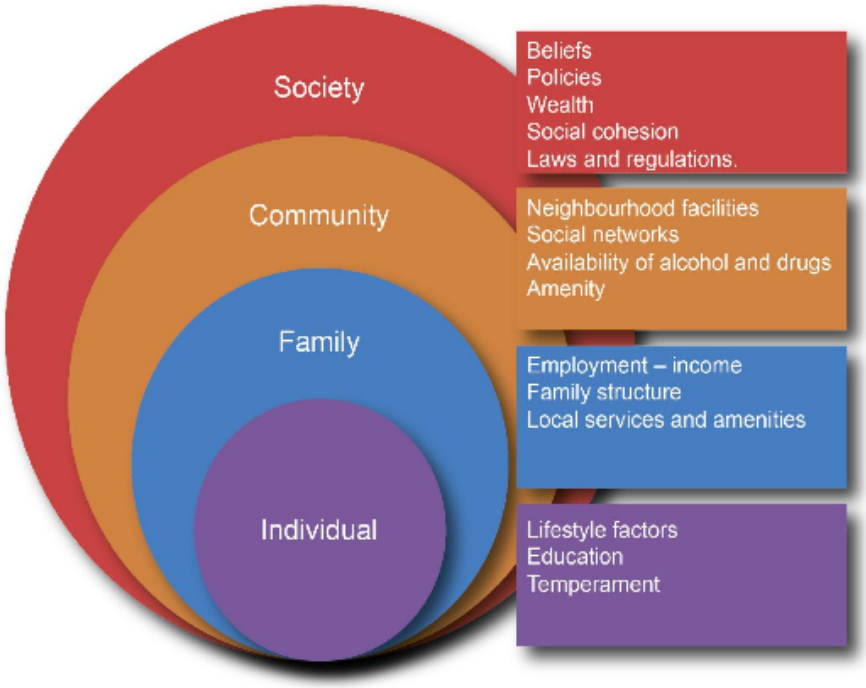
2.4 Integrated care and social and emotional wellbeing

There are several reasons why integrating care for Aboriginal clients with social and emotional wellbeing or mental health issues – including AOD disorders and other addictions including gambling – is particularly relevant for service providers seeking to make a difference in this complex area:

- many Aboriginal AOD clients will be carrying multiple, overlapping and interacting health and social and emotional wellbeing issues at the individual level;
- the history of colonisation in Australia and the contemporary experience of racism may result in significant histories of trauma which not all services are equipped to address; and
- the social determinants of health (poverty, lack of education, poor housing) profoundly affect individual wellbeing at a family, community and societal level (See *Figure 1*);
- problems with service access and coordination may be exacerbated in conventional mainstream service systems by poor cultural responsiveness in some service providers, low health literacy amongst some clients, and different conceptions of health and wellbeing between client and provider;
- funding systems, particularly competitive tendering processes and short-term single-purpose funding, may lead to fragmented service systems marked by competition rather than collaboration.

In addition, and perhaps most significantly, the kind of holistic care promised by integration aligns much more closely with the Aboriginal concept of social and emotional wellbeing. Instead of providing care and support in isolation for particular issues – for example, mental health, chronic disease management, family issues – an integrated approach seeks to wrap services seamlessly around the client to meet their holistic physical, social and wellbeing needs.

Figure 1: High levels of individual harmful AOD use are embedded within the social determinants of health [13]



2.5 Policy context

There are a number of national strategies that are relevant to the development of integrated care for Aboriginal and Torres Strait Islander people with AOD and other social and emotional wellbeing issues. In particular,

- the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* [3] places integration as a reform goal of the Australian Government for improving care, including access to the three streams of care (medical; psychological; and social and cultural support) that form the core of the Central Australian Aboriginal Congress model (see Module 3),
- the *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* [13] which recognises the important role of Aboriginal and Torres Strait Islander community-controlled organisations in particular in cross-sectoral efforts to ensure integrated approaches, and
- the *Fifth National Mental Health and Suicide Prevention Plan* [14] addresses the need to use regional mental health and suicide prevention planning to achieve a more integrated service system for people with or at risk of mental illness.

Other national strategies include the:

- *National Drug Strategy 2017–2026* [15], and the
- *National Alcohol and Other Drug Workforce Development Strategy 2015–2018* [16].

States and Territories have also developed their own specific plans and strategies and frameworks to guide the development of services in each jurisdiction.

For more information

On Aboriginal and Torres Strait Islander SEWB and alcohol and drug use:

- Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Dudgeon, Milroy, and Walker 2014)
- Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: A thematic review of five research projects (Gray et al. 2014)

On integration:

- Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review (Savic et al., 2017)
- Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions (Sterling, Chi, and Hinman, 2011)
- Integrated care models: an overview (World Health Organisation, 2016)

On the policy environment:

- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (Department of the Prime Minister and Cabinet, 2017)
- National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 - 2019 (Intergovernmental Committee on Drugs, 2015)

3 The Congress model of integrated client care

Objective: to provide a description of how an integrated 'three streams' of care model for those with AOD issues has been developed and implemented at Central Australian Aboriginal Congress.

This module contains the following sections:

3.1 The 'three streams' model

In 2008, Central Australian Aboriginal Congress responded to increasing concerns from the Aboriginal community in Central Australia about the lack of culturally-appropriate non-residential treatment options for Aboriginal people with AOD issues.

Over the years, the model has evolved, developing a more stable funding base and moving to greater levels of integration over time. However, the core of the model has remained the same, based on three inter-related streams of care.

Figure 2: Congress three streams of care

Stream	Provided by	Support provided
Social and Cultural Support	• Aboriginal Care Management Workers (ACMWs) • Aboriginal Cultural Integration Practice Advisor • Social workers	• Client advocacy • Cultural support • Social support • Access to medical care • AOD counselling, brief interventions • Case management
Psychological Therapy	• Psychologists • Mental Health Accredited Social Workers	• CBT and related therapies including Motivational Interviewing, Schema Therapy, Mindfulness Therapies • Brief Interventions • Neuropsychological assessment
Medical Treatment	• Salaried General Practitioners	• Screening for alcohol use • Brief interventions • Chronic disease management • Pharmacotherapies where appropriate

A key assumption has been that the integrated three streams care are the foundation for the treatment of *all* SEWB service clients, whether they present primarily with alcohol use or other drug issues, or with social and emotional wellbeing / mental health issues such as other addictions (e.g. gambling), anxiety and depression.

The model has been evaluated as it developed with conclusions that the model was well-received by stakeholders and clients; that it demonstrated

> *the viability of, and demand for, evidence-based non-residential treatment for Indigenous clients with alcohol problems [17]*

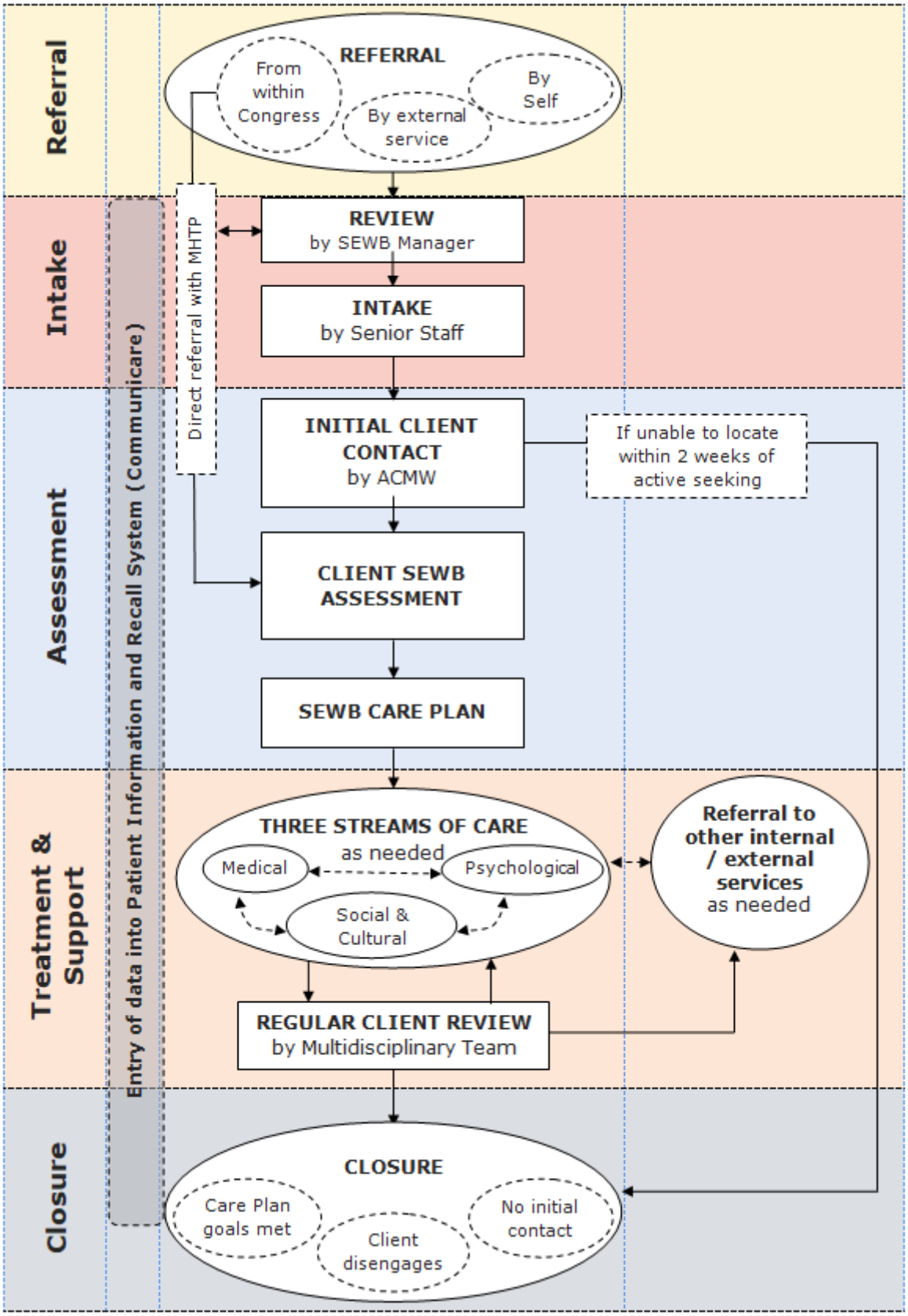
and that it

> *achieved [its] objective of improving the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program [18]*

In 2012 it was found that over half (55%) of active clients in the program showed a decrease in their drinking over the course of their engagement with the program, with clients engaging over a longer period showing greater improvements, despite many bearing multiple markers of disadvantage [18].

3.2 Client care pathways in the 'three streams' model

The provision of the integrated three streams of care follows five stages.



Stage 1: Referral

- internal referrals on the principle of 'no wrong door' for clients to access needed services
- external referrals from other Aboriginal organisations (e.g. residential treatment) of mainstream organisations (e.g. hospitals)
- self-referrals

Congress doctors may also, with the agreement of their client, book them directly into a psychologist appointment with a Mental Health Treatment Plan (MHTP), bypassing the usual intake and initial client contact processes (see below) although they are still reviewed by SEWB Manager to check appropriateness of referral and program coding.

Stage 2: Review and Intake

Review by SEWB Manager

- review of referrals to ensure appropriate for scope of services offered and referral to other internal / external service providers if needed
- follow up of incomplete referrals
- allocation of client treatment to funding program to allow for reporting and acquittal of government funding

Intake by multidisciplinary team of senior staff

- multidisciplinary assessment to determine the needs, cultural context, history and risk assessment of the client
- allocation of client to a primary care giver (psychologist, Aboriginal Care Management Worker, or social worker) taking into account client needs and availability / skill set of practitioners

Primary care giver provides case management as needed for the client for the period they are receiving care.

Stage 3: Assessment and Care Planning

Initial Client Contact by ACMW or other Aboriginal staff

- initial contact for those clients who are marginalised and may have difficulty initiating contact themselves to begin the process of social / cultural support or to encourage and support the client to access other services
- initial contact with clients to take place within one week of their allocation during the intake process
- if no contact is able to be established within two weeks, then case to be reviewed for closure

Client consent and assessment by primary care giver

- client consent to treatment and for appropriate sharing of information on a confidential basis amongst the SEWB team

- client assessment using a semi structured interview approach to complete holistic assessment tool developed within Congress. Includes:
    - a suicide / self-harm risk assessment
    - a violence assessment
- client assessment may also include use of
    - *Here and Now Aboriginal Assessment (HANAA)*
    - *Audit-C* where alcohol indicated as an issue
    - *K5* to provide a broad measure of people's social and emotional well-being
    - *Drug Use Disorders Identification Test (DUDIT)* where other drugs indicated as an issue

  Client assessment may occur over multiple sessions and involve further, more specialized (e.g. neuropsychological) assessments as needed

SEWB Care Plan developed by client / primary care giver

- care plan developed to operationalise client goals and identify who is involved in care (goals, actions, responsibilities, and review dates)
- care plans stored on Client Information System with permissions to restrict access to sensitive information

Stage 4: Treatment and Support

Provision of three streams of care by multidisciplinary team

- Treatment and support provided to meet client goals:
    - Social and Cultural support
    - Psychological therapy
    - Medical treatment
- referrals to other internal / external service providers as needed
- case meetings held with other agencies as needed

Regular client review by multidisciplinary team

- weekly case-management meetings of multidisciplinary teams to review client needs and progress against care plan
- aim to consider each client every three weeks
- high risk clients prioritized
- cases for potential closure reviewed

Stage 5: Closure

Formal case closure by SEWB Manager

- On advice of review where

    - client did not commence treatment and support (e.g. could not be contacted within two weeks of allocation)
    - client declined to engage in service following referral
    - treatment and support completed or no further support is required
    - client moves out of service area (possible referral to service providers in new area)
- Important to manage risk and ensure staff resources able to be allocated to engaged clients requiring care

For more information

- Multidisciplinary care in the management of substance misuse and mental health problems in Indigenous settings (Brown J, et al., 2008)
- Central Australian Aboriginal Congress Safe & Sober Support Service: Final evaluation report (Stearne, 2012)
- The Grog Mob: lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients (d'Abbs et al., 2013)

4 Cultural responsiveness

Objective: to underscore the importance of cultural responsiveness in delivering AOD services for Aboriginal and Torres Strait Islander people

Fundamental to working with Aboriginal people is ensuring that engagement is culturally responsive – ensuring respect for cultural difference.

While terminology may differ – some organisations prefer the terms 'culturally safe' or 'culturally secure' – the development and delivery of culturally responsive alcohol and other drug programs should be based on recognition of the following principles [8]:

- a holistic concept of health and wellbeing grounded in an Aboriginal understanding of the historical factors that have influenced alcohol and other drug-related harm,
- culture as a central core component,
- reinforcement of Aboriginal family systems of care, support and responsibility,
- Aboriginal ownership and control, and
- Aboriginal and Torres Strait Islander communities are very diverse, within and between remote, regional and urban areas.

Cultural competence can be defined as

> *a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations* [19]

This module seeks to highlight the key principles and importance of cultural responsiveness. The journey and process of ensuring organisations and individuals are culturally responsive needs to be tailored for the service provider's specific local context.

This module draws heavily upon Chapter 12 of Working Together (*Cultural competence – Transforming policy, services, programs and practice* [19]) and contains the following sections:

4.1 Cultural competence: principles and practice

Planning and delivery of culturally secure and appropriate health services requires cultural responsiveness to be embedded at all levels of a service provider, including corporate, organisational and care delivery [20].

The aim of cultural competence is to foster constructive interactions between people of different cultures. It encompasses the knowledge, awareness and skills aimed at providing a service that promotes and advances cultural diversity through:

- identifying and challenge one's own cultural assumptions, values and beliefs

- developing empathy and connected knowledge and the ability to see the world through another's eyes, or (minimally) to recognise that others may view the world through a different cultural lens
- acknowledging the influences of culture, ethnicity, racism, histories of oppression and other contextual factors in the experiences of individuals and communities.

The *Ways Forward National Aboriginal and Islander Mental Health Policy Report* identified nine guiding principles in the Aboriginal and Torres Strait Islander social and emotional wellbeing / mental health context [21]. We can summarise these as:

1. **The Aboriginal concept of health is holistic** encompassing spiritual, environmental, ideological, political, social, economic, mental and physical factors
2. **Self-determination is central** to the provision of Aboriginal health services both as a construct of Aboriginal cultures and as a human right
3. **Cultural understanding must shape the provision of care** in both Aboriginal-controlled and mainstream health and mental health service provision
4. **Trauma and loss resulting from colonisation** contribute to the impairment of Aboriginal culture and mental health well-being
5. **The human rights of Aboriginal people must be recognised and respected** and a failure to ensure the achievement of these rights contributes to mental ill-health
6. **Racism, stigma, adversity and social disadvantage drive poor mental health** and must be addressed at a structural level
7. **The strength and centrality of Aboriginal family and kinship** are central to Aboriginal identify and life
8. **There is no single Aboriginal Culture:** Aboriginal people and communities are highly diverse
9. **Aboriginal strengths should be respected, encouraged and appreciated,** including creativity, endurance, humour, compassion, spirituality, and a deep understanding of the relationships between human beings and their environment

Cultural competence may not translate easily or appropriately from one culture to another. Rather it is a commitment to an ongoing process developed in a particular cultural context.

Employing local Aboriginal people – and listening to and valuing their opinions – is a foundational strategy for ensuring that primary health care services are culturally secure. Service locations that are not culturally secure for Aboriginal staff are unlikely to be culturally secure for Aboriginal clients. The cultural security of a service can only be properly judged by Aboriginal people, and particularly Aboriginal service users.

The following elements enhance cultural competence at the level of individual practitioners.

Figure 3: Cultural competence at the level of individual practitioners [19]

Element	Description
Knowledge	Broad or generic understanding of the nature of worldviews and culture, and the implications of culture for understanding human behaviour An understanding of the specific cultural and historical patterns that have structured Aboriginal and Torres Strait Islander lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia
Values	An awareness by professionals of their personal values and beliefs A capacity and willingness to move away from using their own cultural values as a benchmark for measuring and judging the behaviour of people from other cultural backgrounds An awareness of the values, biases and beliefs built into the practitioner's profession and an understanding of how these characteristics impact on people from different cultures
Skills	Practitioners require a mix of generic skills to carry out their role; they also need to develop a repertoire of skills that build on their knowledge and values to work effectively as a professional in intercultural contexts. These skills include the ability to: • work as a team member • work collaboratively with a broad range of health services and providers • incorporate the principles of culturally sensitive practice • self-monitor and critically self-reflect.
Attributes	Reflecting on our individual values and attitudes involves the skill of critical reflexivity, which includes, among other things, developing an understanding of: • the nature and dynamics of power as it operates in many levels from practitioner–client interaction, to organisational and political systems and between various professions and disciplines • the nature and impacts (on both Aboriginal and non-Aboriginal people) of unearned or ascribed privilege • the nature and effects of racism at individual, institutional and ideological and discipline levels • the history of relationships between Aboriginal Australians and systems and professions and the effects of this history on Aboriginal perspectives about the professions • the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledges/theories used by the profession • the effects of white privilege, racism and cultural blindedness.

4.2 Instruments for cultural competence audits

This section presents examples of instruments that can be used as a starting point for individuals and organisations to inform discussions about their cultural competence/responsiveness.

4.2.1 Undertaking an individual cultural competence audit [19]

Campinha-Bacote [22] developed a mnemonic 'ASKED' which poses some critical reflective questions regarding one's awareness, skill, knowledge, encounters and desire. Walker et al adapted these questions with permission to encompass working with Aboriginal and Torres Strait Islander peoples.

Figure 4: Key questions for an individual cultural competency audit [22]

Consider each of these questions honestly.	
Awareness	• Am I aware of culturally appropriate and inappropriate actions and attitudes? • Does my behaviour or attitudes reflect a prejudice, bias or stereotypical mindset?
Skill	• Do I have the skill to develop and assess my level of cultural competence? • What practical experience do I have?
Knowledge	• Do I have knowledge of cultural practices, protocols, beliefs, etc? • Have I undertaken any cultural development programs?
Encounters	• Do I interact with Aboriginal and Torres Strait Islander persons? • Do I interact with culturally and linguistically diverse persons? • Have I worked alongside Aboriginal and Torres Strait Islander persons? • Have I worked alongside culturally and linguistically diverse persons? • Have I consulted with Aboriginal and Torres Strait Islander persons or culturally and linguistically diverse groups?
Desire	• Do I really want to become culturally competent? What is my motivation?
Additional questions	• What do I know about the culture, values, beliefs, individual and collective history and social circumstance of the clients/families/communities with whom I work? • Whose standards have we accepted as the key standard for comparison? • Whose ways of living are privileged? • What are the implications of imposing my understandings on people?

4.2.2 Undertaking an organisational cultural competence audit

Westerman [23] lists five key components of organisational competence:

1. local Indigenous-specific knowledge

2. skills and abilities for being able to adapt or utilise mainstream training in a way that will be effective with Indigenous clients
3. resources and linkages for the use of cultural consultants, cultural guides, having lots of links with the local community
4. organisational structures, ensuring that those are actually consistent with culturally appropriate practice
5. beliefs and attitudes—which is the most important?

Figure 5: Key questions for an organisational cultural competence audit [23]

Taking these components into account, does the organisation:	
Context (organisational environment)	• Promote and foster a culturally friendly environment? • Is it located in an area where Aboriginal and Torres Strait Islander persons may wish to access services? • Do the staff display attitudes and behaviours that demonstrate respect for all cultural groups?
Practices (culturally inclusive)	• Involve or collaborate with Aboriginal and Torres Strait Islander persons when planning events, programs, service delivery and organisational development activities? • Develop policies and procedures that take cultural matters into consideration? • Provide programs that encourage participation by Aboriginal and Torres Strait Islander persons? • Use appropriate communication methods and language, e.g. Appropriate and relevant information communicated through user and culturally-friendly mediums?
Relationships (collaborative partnerships)	• Have knowledge of local Aboriginal and Torres Strait Islander groups? • Have knowledge of local Aboriginal and Torres Strait Islander protocols? • Actively involve Aboriginal and Torres Strait Islander persons or groups? • Have a strategy for community engagement?
Service delivery (outcomes)	• Develop and/or implement a collaborative service delivery model with other organisations relevant to the specific cultural needs of the clients? • Provide culturally responsive services that meet the cultural needs of clients?

For more information

- *Cultural Competence – Transforming Policy, Services, Programs and Practice* Roz Walker, Clinton Schultz and Christopher Sonn, Chapter 12 pp 195 – 220 in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*

Pat Dudgeon, Helen Milroy and Roz Walker (eds) Second edition, 2014, Commonwealth of Australia

- *Binan Goonj, Bridging cultures in Aboriginal health* Anne-Katrin Eckermann, Toni Dowd, Ena Chong, Lynette Nixon, Roy Gray and Sally Margaret Johnson 3rd Edition, 2010, Elsevier

- *Looking Forward Aboriginal Mental Health Project: Final Report*. Wright, M, O'Connell, M, Jones, T, Walley, R and Roarty, L, 2015, Telethon Kids Institute, Subiaco, Western Australia. Audio presentation: *From engagement to impact: The Looking Forward Project*

5 Trauma-informed, healing-focused care

Objective: to contextualise AOD services for Aboriginal and Torres Strait Islander people in trauma-informed, healing-focused service delivery systems

Past policies and practices directed at Aboriginal and Torres Strait Islander peoples have left a legacy of contemporary trauma and unresolved loss and grief, and the need for individual, family and community healing [24].

The high prevalence of grief, loss and substance misuse among Aboriginal people are as much symptoms as causes of traumatic stress [25].

Healing-focused services are underpinned by Aboriginal self-determination and are led by, and focused on Aboriginal people.

This module contains the following sections:

5.1 Why trauma and healing matter in AOD services

The high prevalence of grief, loss and substance misuse among Aboriginal people are as much symptoms as causes of traumatic stress [25].

Past policies and practices directed at Aboriginal and Torres Strait Islander peoples have resulted in a form of cultural genocide, including dispossession and removal from traditional lands and forced removal of children. These acts have left a legacy of contemporary trauma and unresolved loss and grief. Such intergenerational trauma can have significant negative psychological and social consequences including [26]:

- violation of the sense of safety, trust and self-worth,
- emotional distress, shame and grief,
- aggression and difficulty negotiating relationships,
- disruption of attachment styles, which can lead to interpersonal difficulties,
- adoption of negative behaviours such as smoking, drug and alcohol misuse and physical inactivity, and
- increased incidence of chronic diseases such as heart disease, cancer, diabetes, liver disease and depression.

Compared to Aboriginal and Torres Strait Islander people of a similar age who were not removed, Stolen Generation survivors are significantly more likely to:

- **have poor physical and mental health**
- **not own their own home, have experienced homelessness, and be unemployed**
- **have experienced violence and/or discrimination in the previous 12 months**
- **have been incarcerated, arrested and/or formally charged by police.**

The descendants of Stolen Generations are also disproportionately disadvantaged compared to other Aboriginal and Torres Islander people consistent with the impact of unresolved intergenerational trauma.

AIHW, 2018 *Aboriginal and Torres Strait Islander Stolen Generations and descendants: numbers, demographic characteristics and selected outcomes* AIHW and The Healing Foundation, Canberra.

Addressing the harmful use of alcohol and other substances must therefore

> *start with the facts – each Aboriginal person has a lived experience and story that should be told by them [8]*

The capacity to listen to and witness these human stories without judgement is vital, together with responses that are not re-traumatising.

Overcoming trauma-related distress means addressing the suffering of the individual and also the prevalence of events within the community that lead to re-experiencing and poor outcomes [27].

A first step is a service provider explicitly acknowledging and understanding the impact of the colonial legacy on the lives of Aboriginal people and the pathways necessary for healing from historical trauma, using both cultural and contemporary understandings and processes.

Three themes collectively promote healing and recovery across generations [28]:

- self-determination and community governance
- reconnection and community life
- restoration and community resilience.

An effective way of enhancing social and emotional wellbeing is through programs that enhance and build on Aboriginal peoples' unique sources of strengths and resilience linked to social cohesion, connections to family and kin, country and cultural identities.

Service providers need to engage with the diversity of cultures and language groups and develop programs to meet local needs rather than adapting and delivering models designed for

"An important part of healing is understanding how using alcohol and other drugs at harmful levels impact on our spirit, our people, our culture and our country. We need to understand this and use this knowledge to make better choices"

Casey W., 2014 Strong Spirit Strong Mind Model – Informing Policy and Practice Ch 26 p452 p125 in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* Pat Dudgeon, Helen Milroy and Roz Walker (eds) Second edition, 2014, Commonwealth of Australia

mainstream Australians, or assuming that for Aboriginal people 'one size fits all' [29].

5.2 Trauma-informed care

Substance misuse can be a symptom of trauma. Organisations delivering AOD services need to recognise that trauma can have significant impacts on staff, members of governance groups, managers as well as clients.

Delivery of trauma-informed services requires organisations, teams and individuals to [26]:

- understand trauma and its impact on individuals, families and communal groups
- promote safety by creating environments where people feel physically, emotionally and spiritually safe
- employ culturally competent staff and adopt practices that acknowledge and demonstrate respect for specific cultural backgrounds.
- support people who have experienced trauma to regain a sense of control over their daily lives and to be actively involved in all aspects of their lives, including their mental health–social and emotional wellbeing care.
- share power and governance, including involving individuals, families and community members in the development, design, delivery and evaluation of programs.
- integrate and coordinate care to holistically meet the needs of individuals, families and communities, wherever the broad range of mental health, social and emotional wellbeing support services are required.
- support relationship building as a means of promoting healing and recovery from trauma, both for clients as individuals or in groups, and within workforce teams.

Figure 6: Trauma informed organisations checklist [30]

A program, and or organization that is trauma informed:

Realizes the widespread impact of trauma and understands potential paths for recovery

Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Responds by fully integrating knowledge about trauma into policies, procedures, and practices

Resists re-traumatization of clients and staff

Rebuilds connection to community, family and kin, country, culture, body-mind and spirit-spirituality

5.3 Healing-focused organisations

An organisation can be proactive in setting a culture and organisational norms that recognise behaviours as trauma-related, and put in place healing-focused responses.

Enabling recovery supports healing journeys. Healing also focuses on a positive view of wellness, rather than sickness, with wellness considered in the context of family, community, culture, land and spirituality.

The Healing Foundation identifies four primary principles that support healing journeys [31]:

- addressing the causes of community dysfunction, not its symptoms
- recognising the fundamental importance of Aboriginal and Torres Strait Islander ownership, definition, design and evaluation of healing [and care] initiatives
- designing initiatives based on Aboriginal and Torres Strait Islander worldviews, not western health understandings alone
- strengthening and supporting initiatives that use positive, strength-based approaches.

> ***"During every incarceration, every institutionalisation, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. It wasn't until I finally entered a recovery-oriented, trauma informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal… Someone finally asked me 'What happened to you? Instead of 'What's wrong with you?'"***
>
> Tonier Cain, Spoken in relation to experience of a trauma-informed health service (AMSANT)

Deciding to be a healing-focused organisation takes commitment at all levels (board, management and staff [31]. In communities affected by trauma, healing-focused approaches may need to come as a result of strategic decisions, as they do not always arise organically. Areas in which decisions need to be taken are:

- creating positive, healing oriented value systems
- procedures and policies reflecting these values
- the discipline to stick to clearly defined policies and procedures
- good leadership at management and governance levels.

Achieving organisational change is specific to each organisation's context – its activities, structures and where it is currently on its healing journey.

Elements that underpin quality organisational approaches to healing include [32]:

- understanding and recognising the impact of trauma
- addressing issues in the community context
- strong leadership
- proactive approach rather than reactive
- evidence of what works including monitoring the organisation
- building staff, management and governance capacity.

Measures for identifying that an organisation is becoming a healing-focused organisation, and where it might need to do more work could include [31]:

- less violence (physical, verbal, emotional)

- understanding the impact of trauma
- less victim blaming
- clearer, more consistent boundaries and higher expectations (linked to rights and responsibilities)
- better ability to state clear goals, create strategies for change, justify need for holistic approaches
- understanding of repeat behaviour and resistance to change
- better outcomes for clients, staff and the organisation
    - reduced absenteeism especially for stress and chronic disease
    - increased retention
    - more clients report positive interactions with the organisation, staff and managers

For more information

- The Aboriginal and Torres Strait Islander Healing portal brings together information about what is working in Aboriginal and/or Torres Strait Islander healing and includes examples of best practice healing initiatives, the latest research from around Australia and tools people can use to develop healing opportunities in their communities.
- *Addressing Individual and Community Transgenerational Trauma,* Judy Atkinson, Jeff Nelson, Robert Brooks, Caroline Atkinson and Kelleigh Ryan, Ch 17 pp 289 -306 in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* Pat Dudgeon, Helen Milroy and Roz Walker (eds) Second edition, 2014, Commonwealth of Australia
- *Healing Informed Organisations,* Aboriginal and Torres Strait Islander Healing Foundation, 2015

6 Building and supporting multidisciplinary teams

Objective: To enable health service planners/managers to establish and support the multidisciplinary teams that are required to deliver AOD care that is integrated across the three streams of care: medical, therapeutic and social and cultural support, and which is focused on client needs.

An integrated, multidisciplinary approach involves

> *team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities.[6]*

It's easy to get good players. Getting them to play together, that's the hard part.

Casey Stengel (American Baseball League)
SOURCE: Developing Effective Teams, Skinner et al Module 3, NCETA Workforce Development TIPS

An effective multidisciplinary team:

- understands, values and respects the perspectives, competencies and contributions of all team members
- communicates well
- has review, reflection and learning embedded in its processes

This module draws heavily on Chapter 3 (*Developing Effective Teams*) of the *NCETA Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field* [33] and also relies on the material presented in Chapter 13 (*Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing*) of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* [34]. It contains the following modules.

6.1 Characteristics of an effective multidisciplinary team

Nancarrow et al describe 10 themes displayed by effective multidisciplinary, health care teams [35].

Figure 7: Effective multidisciplinary team checklist [35]

Themes	Description
Leadership and management	Having a clear leader of the team, with clear direction and management; democratic; shared power; support/supervision; personal development aligned with line management; leader who acts and listens.
Communication	Individuals with communication skills; ensuring that there are appropriate systems to promote communication within the team.
Personal rewards, training and development	Learning; training and development; training and career development opportunities; incorporates individual rewards and opportunity, morale and motivation.
Appropriate resources and procedures	Structures (for example, team meetings, organizational factors, team members working from the same location). Ensuring that appropriate procedures are in place to uphold the vision of the service (for example, communication systems, appropriate referral criteria and so on).
Appropriate skill mix	Sufficient/appropriate skills, competencies, practitioner mix, balance of personalities; ability to make the most of other team members' backgrounds; having a full complement of staff, timely replacement/cover for empty or absent posts.
Climate	Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere.
Individual characteristics	Knowledge, experience, initiative, knowing strengths and weaknesses, listening skills, reflexive practice; desire to work on the same goals.
Clarity of vision	Having a clear set of values that drive the direction of the service and the care provided. Portraying a uniform and consistent external image.
Quality and outcomes of care	Patient-centered focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care.
Respecting and understanding roles	Sharing power, joint working, autonomy.

6.2 Building and supporting effective multidisciplinary teams

6.2.1 Shared goals, objectives and values

Effective teams have a common frame of reference identified by explicit team goals, specific and concrete objectives and clear values that drive the direction of the service and care [33].

Conducting goal setting with opportunities for all team members to participate will strengthen their commitment to shared outcomes and benefits for clients [36].

Examples of values that underpin effective multidisciplinary teams include:

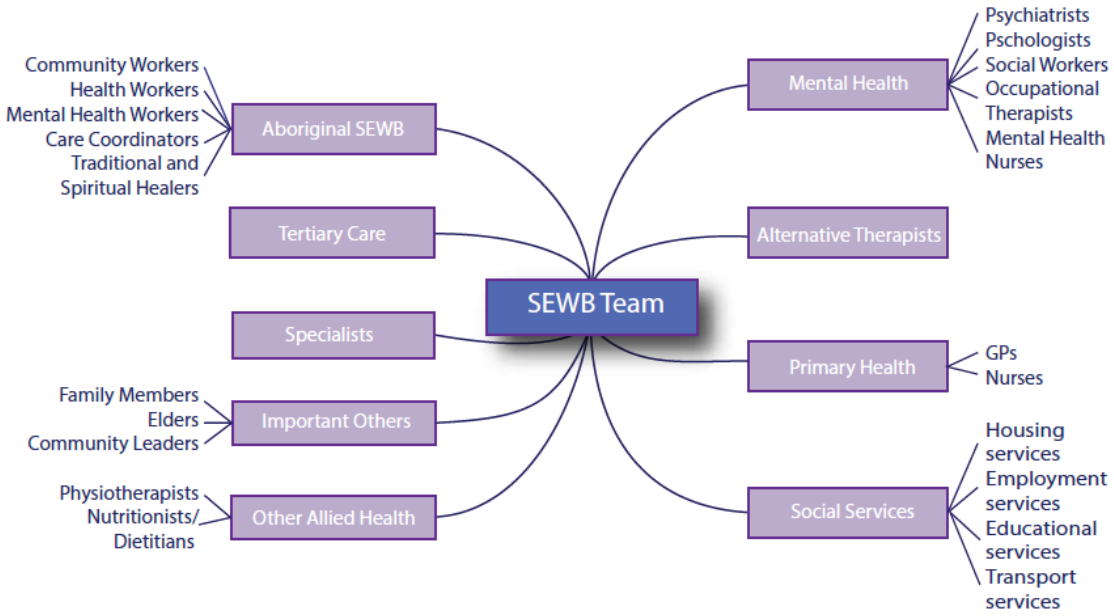
- Commitment to critical self-reflection
- Adopting a stance of resource-sharing
- Recognising the unequal power inherent in practitioner-client relationships and acknowledging what that means for the clients' sense of wellbeing
- Empowering clients to address their SEWB issues including grief, loss and trauma [19].

6.2.2 Team composition (including size and roles)

Effective, inclusive care for Aboriginal and Torres Strait Islander peoples incorporates the physical, social, cultural, spiritual and emotional wellbeing aspects of care. The health team needs members from different disciplines including Aboriginal health and/or care workers, doctors, therapists and social workers [34]

Multidisciplinary teams delivering AOD services have different areas of expertise. This diversity of roles and disciplines enables members to draw on different experiences, understandings and disciplines to problem solve.

Figure 8: Potential Members of an Interdisciplinary SEWB Team [34][1]



The multidisciplinary team developed at Central Australian Aboriginal Congress includes

- Aboriginal Care Management Workers (ACMWs)
- Aboriginal Cultural Integration Practice Advisor
- Social workers
- Psychologists
- Mental Health Accredited Social Workers
- Salaried General Practitioners

See Module 3 for details. Sample job descriptions for some of these roles can be found in section 6.3 below.

Team membership needs to achieve a balance between the required mix of skills, knowledge and experience and maintaining a manageable size. Team size should be kept to the smallest number of people required to do the job effectively. Teams of 4–7 members readily allow effective coordination, communication and decision-making [33].

Taking an integrated approach to care is likely to require staff to operate differently. This may need to be formally reflected in their position statements as well as in feedback and performance assessment systems.

Key requirements for team members

- Team oriented and good communicators
- Trauma informed, healing-focused

[1] Copyright. May need specific permission to use

- Culturally responsive, understand local community needs
- Discrete, tactful
- Confidence for negotiation
- Can accommodate ambiguity
- AOD and/or mental health experience/training/qualifications
- Able to use organisational IT/client information system
- Able to apply self-care to avoid burn-out

Strict assignment of roles and responsibilities is not optimal or realistic in an integrated AOD care setting. Flexibility in team member roles is likely to enhance team effectiveness. Nonetheless it is important that there is a shared understanding amongst team members about the boundaries of their roles and for providers, consumers and carers to understand clearly who is responsible for coordinating care.

Roles, responsibilities and scope of practice need to be clarified with due regard to the medico-legal responsibilities of each team member.

Being comfortable with ambiguity and working outside of one's comfort level is important, as is being able to negotiate and bring together and work with different knowledges and expertise [19].

Developing systems for communicating / documenting tasks and allocating responsibilities can assist to avoid overlap and confusion.

Activities that support role clarification include [37]:

- Weekly meetings between the care manager, primary care physician and psychiatrist
- Regular peer support teleconferences with other care managers to discuss their work
- Development of integrated care protocol
- Regular meetings for mutual support

6.2.3 Leading multidisciplinary teams

Team leaders have a significant influence on the effectiveness of a multidisciplinary team [33]. Effective team leaders [38]:

- are responsible for ensuring that team members are sharing information; monitoring situational cues, resolving conflicts and helping each other as needed
- manage resources to ensure the team's performance
- facilitate team actions by communicating through informal information exchange sessions
- developing norms for information sharing
- ensuring that team members are aware of situational changes to plans.

Key leadership behaviours for a multidisciplinary team include [33]:

- modelling and rewarding behaviours required to operate effectively in a diverse team
- encouraging team members to express disagreements or doubts and challenging team perspectives and decisions to encourage discussion and debate
- resisting pressure to gain "quick closure" by accepting compromises or forcing consensus early in the group discussion
- ensuring that the group operates with just and fair processes (i.e., applying rules consistently, ensuring opportunities for participation in group discussion)
- focusing rewards and reinforcement at the team rather than individual level

The team leader needs to balance the need to encourage and support debate and sharing of different perspectives with the need to support team cohesion.

Giving teams freedom (autonomy) to do their jobs to a high standard in the best way they can improves motivation, job satisfaction, commitment and confidence, and provides opportunities to use current skills and learn new skills [39].

Three key supervisory behaviours for supporting autonomous work teams are [33]:

- negotiating with the team to set clear boundaries and limits on the amount of decision-making authority and discretion provided to the team
- ensure the team contains the required mix of knowledge, skills and ability to effectively operate as an autonomous group
- ensure team members have a shared understanding of roles, responsibilities and lines of authority.

6.2.4 Managing team processes

Effective multidisciplinary teamwork requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices [34].

A key challenge for multidisciplinary teams is managing internal social processes (such as power, authority, coalition-formation) to ensure that teams can effectively draw on their collective knowledge and experience [33]. The interplay of processes for maintaining a multidisciplinary team are listed in the following table bess [34].

Figure 9: Maintaining a multidisciplinary team [34]

Element	Includes:
Communication	Communication within the team environment takes place in both verbal and non-verbal forms. Communication which is open and free-flowing between team members provides the basis for effective care outcomes Effective team communication is a shift beyond the traditional silo approach to care.
Team emotions	Team emotions can play a significant role in the effectiveness of teams and the positive clinical outcomes Team 'membership' carries a distinct set of emotions due to the attachment often felt with colleagues and the commitment felt to provide effective outcomes.
Trust and respect	Often developed via shared experiences and the ability for individuals to demonstrate clinical competence New team members will often need to 'prove' competence Development and maintenance of trust and respect within the team will promote a stable team Absence of such important qualities will result in problematic behaviours amongst the team members.
Humour	May support resilience by relieving the general stressors and strains of working closely with other professionals.
Conflict	Different team members bring different ideas, goals, values, beliefs and expectations to the team Can act as a barrier for team performance Can strengthen team performance if it enhances innovation, quality and creativity Is likely to occur with multiple individuals working closely together from different disciplines Important for the team to agree early on how they will resolve conflict.

Element	Includes:
Team stability	Team stability produces positive outcomes due to the development of mutual respect, trust and goals. Tips for maintaining team stability: Set standards for accomplishing tasks and for team behaviour Encourage each team member to contribute by reinforcing the importance of equality and interdependence Seek harmony when conflict occurs by acknowledging difference and listening carefully and respectfully to all opinions Brainstorm collectively for possible solutions and focus on common interests amongst team members Seek consensus amongst team members in arriving at the most appropriate decision Remain open to giving and receiving feedback about positive and/or negative behaviour, decisions, outcomes Review and evaluate progress at the conclusion of interaction and be open to constructive criticism regarding the team's functionality
Team building	Can assist to enhance individual attitudes, skills, knowledge and behaviour both toward desired goals and each other Can promote collaboration and improve performance of team members Critical reflection activities allow teams to adopt and respond to change within the team environment.

6.2.5 Acknowledging and managing power differentials

All practitioners need to accept, acknowledge and respect the different skills and valuable experiences that are brought to the team [34].

Working effectively in multidisciplinary teams requires the power differential that may occur between doctors/psychiatrists and other team members to be acknowledged.

Leadership styles need to facilitate trust and team work, rather than being based on control and power.

When working with Aboriginal and Torres Strait Islander clients and health workers, these power differentials can arise from both the assumed authority inherent in the medical discipline/profession and the implicit status of white privilege of medical personnel [34].

Letting go of the 'expert' role and sharing resources can be difficult for practitioners accustomed to being in professional control [19]. It involves:

- being critically self-reflective and considering your own values, attitudes, privilege and power
- recognising that clients, their family and community, Aboriginal co-workers and other professionals are equally experts.

Guidelines and codes of ethical conduct are useful resources for practitioners [19].

All practitioners, both Indigenous and non-Indigenous, tend to operate according to a complex interaction of their own values, beliefs and experience and the values, assumptions and paradigms of their professional discipline or field. The way individual practitioners carry out their roles, and the way they act with clients and other professionals depends largely on their interpretation of that discipline which is largely influenced by their own beliefs, values, knowledge and experience

Walker R, McPhee R, Osborne R. Critical reflections for professional development. In: Dudgeon P, Garvey D, Pickett H, editors. Working with Indigenous Australians: A handbook for psychologists. Perth: Gunada Press; 2000 cited in Walker et al, 2014 Ch 12, Working Together

6.2.6 Communication

Regular, open communication is an essential component in delivering effective, integrated AOD care. It supports positive feedback and recognition, and allows any issues to be acknowledged and action taken to reconcile problems.

Good communication is critical to establishing and embedding new ways of delivering service, such as the three streams model of AOD care.

A range of communication strategies can be used to increase awareness and understanding in the team and across the organisation of the need for and benefits of a more integrated, multidisciplinary model of AOD care [40]:

- persuasive communications from management, supervisors and other key stakeholders (eg former clients) eg speeches, articles, posters, emails
- face to face meetings including question and answer forums
- active participation in establishing new processes and arrangements
- professional development, performance appraisal
- symbolic activities celebrating success, new ways of doing things eg ceremonies and awards

The key principles that underpin co-production are adjusting power imbalances and fostering reciprocal relationships between professionals and people using services and their families. In an Aboriginal context it also means ensuring trust, inclusivity, and flexibility are developed

Wright, M, O'Connell, M, Jones, T, Walley, R and Roarty, L, 2015 Looking Forward Aboriginal Mental Health Project: Final Report. Telethon Kids Institute, Subiaco. Western Australia

- policy and procedural changes.

Effective communication between practitioners includes [37]:

- processes such as care planning, guideline development, referral and follow up protocols
- structured communication and communication channels such as regular meetings and case conferences
- receptive partnership culture, such as open door communication style and willingness to try out new ideas
- timely feedback, monitoring and reflecting on how service delivery meets client needs and evidence of what is changing.

6.2.7 Workforce support strategies

Figure 10: Workplace support strategies for AOD workers [41]

	Social / emotional support	Instrumental support
Organisation	• Ensuring fairness of treatment • Providing valued rewards • Ensuring supportive supervision	• Ensuring good job conditions (physical safety, job security, promotion paths, autonomy) • Addressing work overload • Addressing role ambiguity or conflict • Providing access to high quality resources and equipment
Managers / supervisors	• Channelling / facilitating organisational support • Providing positive social interaction (praise, encouragement, caring, respect) • Recognising and rewarding good work • Involving workers in decision-making	
Co-workers	• Providing positive social interaction (praise, encouragement, care, respect) • Providing help and advice • Filling in when others are absent • Assisting with heavy workloads • Providing constructive feedback • Appreciation and recognition • Sharing duties and responsibilities	

(a) Providing performance feedback

Timely and constructive feedback is an important tool for improving team effectiveness, and increasing individual motivation and job satisfaction. An important role for team leaders is to manage the team feedback process.

As far as possible, all team members should be rewarded and recognized based on the team's performance. Reward and recognition for individual team members should be provided in the context of their contribution to the team effort.

Team leaders can use a range of techniques to ensure that a team feedback session is constructive and beneficial for team performance.

Figure 11: Techniques for team feedback [33]

Strategy	Rationale
Putting forward an honest appraisal of your own performance (including flaws / mistakes) early in the feedback process	Helps to create a constructive and open atmosphere where mistakes and shortcomings can be acknowledged and used to help problem-solving
Taking on feedback and ideas from team members	Models an open attitude to others' opinions, encourages participation and willingness to discuss alternative views and identify problems
Focusing feedback on the task rather than the person	Feedback is more likely to be accepted if phrased in terms of behaviours and tasks, rather than personality traits or motivations of individuals
Making feedback specific and focused on solutions	Feedback is most helpful when it identifies specific tasks or behaviours and provides direction on how to improve future behaviour
Ensuring team feedback is a two-way communication process between the leader and team members (e.g., what is working well for your group at present?)	The use of open-ended questions for reciprocal feedback encourages the team to analyse problems and suggest solutions
Structuring feedback sessions to include discussions of teamwork processes, as well as key tasks and outcomes	Open discussion on the quality of team processes such as communication, coordination and support can assist future performance
Referring to previous feedback sessions to identify areas that have been improved and highlight recurring errors	Using feedback to encourage a sense of achievement and progress can be a powerful motivator
Using the feedback session to recognise and reward improvements and achievements	Recognition and rewards are powerful influences on team members' motivation and confidence

Rewards do not have to be financial. Powerful non-financial rewards include [33]:

- Public recognition and praise
- Team celebrations
- Preferred work assignments, roles or responsibilities
- Opportunities to act in higher duties
- Attendance at workshops / conferences.

(b) Support to avoid stress and burnout

Workers in the health and human services field can experience high levels of work-related demands and stressors, and are particularly vulnerable to stress and burnout [42]. Workers in the AOD field in particular face many significant challenges related to:

- The client population (complex circumstances, stigmatisation of drug use, reluctance to engage in treatment)
- Community attitudes towards drug users (and the people who work with them)
- The need to continually develop and refresh knowledge and skills to manage changing treatments and complex client presentations (e.g., polydrug use)
- Working conditions (e.g., remuneration, availability of professional development, job security access to clinical supervision [43], heavy client workloads).

In addition, Aboriginal and Torres Strait Islander workers bear a 'cultural load' – "a sense of the accumulation of factors/trauma that builds over time and causes [at a] minimum angst, [at] maximum stress, to daily living and working [31].

Supportive supervisors and managers have a positive impact on workers' psychological and physical wellbeing. Managers and supervisors can support effective team functioning by [33]:

- Adopting trauma-informed and healing-focused approaches (see trauma module)
- Providing access to human and material resources (practical support)
- Providing encouragement to the team (symbolic support)
- Allowing sufficient time for effective performance.

> ***An interdisciplinary team approach enables the burden of care to be more equitably shared and has the potential to address the experiences of disempowerment, burnout and even self-harm and suicide anecdotally noted within the Aboriginal and Torres Strait Islander health/SEWB professional and paraprofessional workforce through more team and support strategies.***
>
> Schultz et al, 2014 Ch 13, Working Together (p228)

Job resources linked to the reduction in stress and burnout include [33, 39]:

- Understanding Aboriginal and Torres Strait Islander ways of working and working in culturally appropriate ways including the importance of connecting to country

- Self-care planning including debriefing [44, 45]
- Career development
- Support relationships with colleagues
- Availability of high quality and supportive supervision including internal and external clinical supervision and mentoring
- Organizational structure and climate – opportunity for participative decision-making, healthy office politics, workloads managed, supportive administrative and coordination systems
- Autonomy
- Opportunities to use skills
- Task variety
- Role clarity
- Flexible work times
- Appropriate remuneration
- Reinforcement and rewards

For Aboriginal team members and for service providers based in remote areas, it is likely that client-practitioner interactions will occur in non-work situations. Team members may need additional support to develop and adopt strategies to prevent and reduce stress.

For more information

- *Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing*, Clinton Schultz, Roz Walker, Dawn Bessarab, Faye McMillan, Jane MacLeod and Rhonda Marriott Ch 13 pp 221 – 242 in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice Pat Dudgeon, Helen Milroy and Roz Walker (eds) Second edition, 2014, Commonwealth of Australia
- Theory Into Practice Strategies (TIPS): A Resource Kit for the Alcohol and Other Drugs Field N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd eds, 2005 National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, Australia.
- Developing Effective Teams, Skinner, N. 2005 Module 3 in N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (eds), *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field.* National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, Australia.
- Health LEADS Australia: the Australian Health Leadership Framework, Health Workforce Australia, 2013
- Goal Setting, Skinner, N, 2005 Module 5, in N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (eds), *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field.* National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, Australia.

- Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene. Roche, A and Pidd, K., 2010. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.
- Staying deadly: Strategies for preventing stress and burnout among Aboriginal & Torres Strait Islander alcohol and other drug workers. Roche, A.M , Nicholas, R. Trifonoff, A., & Steenson, T., 2013, National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA.

Appendix: Sample position descriptions

Aboriginal Integration Practice Advisor

The Aboriginal Integration Practice Advisor has a strategic role in Social and Emotional Wellbeing (SEWB) and is responsible for providing high level cultural advice and support to the team including:

- Enabling effective and culturally appropriate delivery of SEWB programs and services;
- Assisting in developing strategies to address identified issues; and
- Providing cultural mentorship to SEWB management and staff.

The Practice Advisor will also manage a caseload and deliver culturally appropriate advocacy, support and liaison to Aboriginal people presenting to SEWB with a broad range of issues.

LINK TO FULL JOB DESCRIPTION

Aboriginal AOD Care Management Worker

The Aboriginal AOD Care Management Worker provides support to clients, carers and families to address mental health, social and emotional wellbeing, alcohol and other drug associated issues. The position works within a multidisciplinary team to facilitate holistic care enabling access to medical and therapeutic care and delivering culturally appropriate social support and advocacy.

LINK TO FULL JOB DESCRIPTION

7 Building capacity and competency in the AOD workforce

Objective: To enable health service planners/managers to build capacity and competency at the organisational, team and individual level to effectively deliver integrated (3 stream) AOD services.

A skilled, knowledgeable and effective AOD workforce doesn't happen by accident. AOD agencies, governments and training providers need to think and act creatively in order to create ongoing professional development opportunities for AOD practitioners.

Opportunities for highly practical and tailored learning can be provided in-house and will complement formal (and costly) education and training activities.

Professional development activities need to offer more than AOD-specific activities, for example developing skills in negotiation, leadership and management among the AOD workforce [46].

Professional development may need to occur at the organisational, team and/or individual levels, with team-based learning most effective for reinforcing integrated care.

Effective work practice change requires intervention at a range of levels – including clients, AOD professionals or practitioners, supervisors, managers and agencies

From NCETA Workforce Development TIPS Module 9 Professional Development

Given the time and financial constraints facing service providers, professional development strategies requiring modest time, financial or staff resource commitments are preferred.

This module contains the following section(s):

7.1 Supporting effective, integrated services

Effective professional development programs for AOD workers should focus on [47]:

- Experiential learning methods
- Focused on knowledge, skills and attitudes
- Clear learning objectives
- Quality resources

Programs should be:

- Informed by evidence-based practice
- linked to accepted standards
- assessed and evaluated

- relevant to the workplace roles and linked to succession planning

Key professional development activities that can meet AOD workers' needs include:	
• Study groups	• Journal clubs
• Mentoring	• Online discussion groups
• Clinical supervision	• Cross-organisational exchanges
• Planning days	• Online learning
• Site visits	• Professional association membership
• Staff retreats	• Education and training

Opportunities for highly practical and tailored learning can be provided in-house and will complement formal (and costly) education and training activities. Advantages of in-house activities include access corporate to knowledge and skills already held in the organisation and the capacity to provide highly tailored, practical learning [48].

If service providers have a high turnover of staff, especially in medical/psychotherapy areas, they may find that these temporary team members are not particularly knowledgeable about integrated care, and will need to take additional care to ensure that they understand the imperatives and processes involved through induction and training.

Shared training opportunities provide team members with shared knowledge and understanding, increasing the likelihood that learning will be applied in the workplace. In remote areas, shared training can be a cost-effective means to deliver professional development, especially if costs can be shared with other organisations who have staff who will benefit from the training.

Where health service providers have integrated AOD care as part of their standard approach to SEWB services, some have cross-trained mental health and AOD care workers so that they have common knowledge and understandings that can be applied to working with clients.

Key strategies that support workers to apply newly developed knowledge and skills in their work practice include [49]:

- Giving follow up presentations to the team
- Sharing with the team and agreeing on how new knowledge will be applied
- regular follow-up and/or evaluation of the impact of professional development on workplace practice including through clinical supervision
- Supporting and encouraging the team to acknowledge individual staff members' specific knowledge, skills and strengths
- Supporting employees to become credentialed as trainers in their areas of expertise or specific core competency training
- Supporting or coordinating collective training and information exchange with key partner organisations
- Affirmation and other rewards (see Workforce Support Strategies, Module 6).

For AOD teams delivering services to Aboriginal and Torres Strait Islander peoples professional development should [47]:

- include community input into program design
- provide for negotiation and consultation with key stakeholders including elders and community members
- ensure all parties are recognised and involved
- emphasise a supporting learning environment that recognises skills and abilities
- places high value on cultural responsiveness
- be relevant to employer and workplace expectations
- articulate with formal education/training courses (VET and/or higher education)
- where appropriate lead to accreditation
- be relevant to the careers of workers
- enable positive outcomes to be achieved for clients.

The content of this training must [47]:

- be developed with the context of AOD issues for Aboriginal and Torres Strait Islander peoples, ie recognising diversity of people's history and experience, trauma-informed and healing-focused
- take a holistic approach that accounts for the cultural, spiritual, social, emotional and physical determinants of Aboriginal and Torres Strait Islander health and wellbeing.
- Give overviews of AOD issues and Aboriginal AOD use
- Cover topics such as the latest evidence around:
    - Injecting drugs, blood borne viruses, legal issues relating to drug use
    - Prevention, controlled drinking, relapse prevention
    - Harm minimisation
    - Assessment and evaluation
    - AOD models developed by Aboriginal people for Aboriginal people

7.2 Professional development to improve teamwork [42]

Teamwork requires skills in coordination, planning and performance strategies.

Team-based professional development activities could include:

- Coordination of team members' contributions to the team's goals based on the knowledge, skills and experience of individual members
- Enhancing team members' motivation to contribute to the team

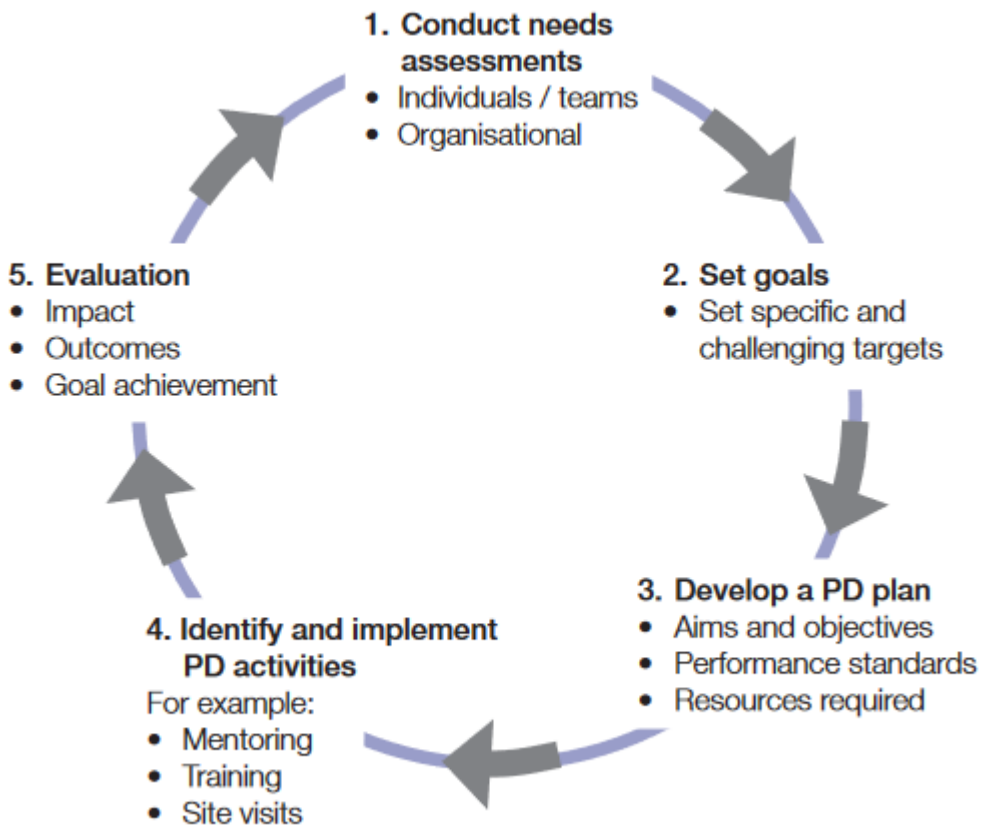
- Effective group decision-making including weighting contributions based on knowledge, skills and experience
- Implementing team performance and decision-making approaches
- Resolving conflict

Coaching, advice and professional development are most likely to be effective:

- Prior to the team starting work
- At regular intervals to reflect on current work practices and areas to improve
- At 'completion' to reflect on experience and identify lessons learned.

7.3 Professional Development Needs Analysis

Figure 12: A Five-Step approach to professional development [48]



7.3.1 Organisational needs assessment

An organizational needs assessment examines the current mix of staff knowledge and skills against organizational goals and major areas of service provision. A further aim of organizational needs assessment is to identify system-wide components of the organization that may affect a learning program (ie organizational goals, resources,

supports for training transfer and work practice change, and internal and external constraints to professional development.

7.3.2 Team needs assessment

It can also be useful to conduct a needs assessment for teams. Team competencies are separate and distinct from individual competencies (not merely a compilation of workers' needs). Individual competency is necessary but not sufficient for effective team performance. Specific team competencies and skills should be identified through the needs assessment phase.

7.3.3 Individual needs assessments

Needs assessments for individual workers are designed to identify areas for knowledge and skill development based on key roles, tasks and responsibilities. Needs assessments for individuals should be linked with organizational goals and may also take into account workers' future career goals.

For more information

- *Professional Development*, Pollard, Y 2005, Module 9 In N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (eds), *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field.* National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, Australia.
- *Comorbidity Capacity Building Toolkit*, 2011, Western Australian Network of Alcohol and other Drug Agencies (WANADA)
- *Alcohol And Other Drug Education And Training For Indigenous Workers: A Literature Review*, Dennis Gray, Ben Haines and Sharyn Watts 2004, The Aboriginal Drug and Alcohol Council of SA Inc.

8 Financing integrated AOD care

Objective: to identify the costs, savings and potential income sources associated with establishing and delivering integrated AOD care services for Aboriginal and Torres Strait Islander people.

Delivering integrated AOD services may require investments in changes to organisational systems, and may also generate new income sources, and possibly efficiencies.

The care team needs members from different disciplines including Aboriginal health and/or care workers, doctors, therapists and social workers. In addition to a multidisciplinary team, integrated AOD care requires hard and soft organisational infrastructure including capacity building, facilitation and coordination, space for discrete conversations, outreach services and ICT systems. As a system-wide approach, it is likely to require process changes at the organisational, team and individual levels.

The extent of investment required will be determined by the size and internal capabilities of the organisation, including what systems it already has in place, and if it is already providing integrated SEWB/clinical care.

This module contains the following sections:

8.1 Investments

This section identifies the resources that health service planners need to allocate for delivering integrated AOD services to Aboriginal and Torres Strait Islander clients, based on the Central Australian Aboriginal Congress experience.

Investment in integration can have benefits regardless of the size of the organisation. Larger organisations may have more internal capability to support the systems changes required, with costs primarily accruing as opportunity costs of diverting internal resources to assist service integration. The larger the organisation, the greater degree of flexibility it will have to provide integrated services. For example, for covering planned or unplanned team member absences.

8.1.1. People

As identified in Module 6, establishing effective multidisciplinary teams comprised of Aboriginal community workers, social workers, psychologists and general practitioners is a critical factor in delivering integrated AOD care.

Congress benefited from having a full-time Social and Emotional Wellbeing Manager who could take responsibility for working with staff across the organisation to drive the cultural, systems and individual behaviour changes required to deliver integrated AOD care. The manager is responsible for staff supervision, and monitoring and reporting outputs and outcomes, in addition to a regular, but reduced clinical load.

Teams are co-located, and are supported by other staff including transport/bus drivers, receptionists, finance and CQI. Formal evaluation is conducted by external consultants.

Another Aboriginal health organisation stressed the importance of ensuring support functions within the organisation (e.g. finance, administration, human resource management etc) understand and support the integrated care model. This includes integrating and training corporate staff from finance and human resources functions.

Training for support staff can include undertaking accredited training in AOD (see Module 7 for more information about capacity building for staff).

8.1.2 Infrastructure

(a) Location

Integrated AOD service delivery can be supported by co-locating members of the multidisciplinary team within the primary health care clinic.

The benefits are:

- Reduced potential of stigmatising clients, who are interacting with the broader health service provider, rather than entering through a 'labelled' door.
- Ease of introductions and referrals so that clients quickly feel more comfortable
- Increased potential for interaction, information sharing and case conferencing between team members

Availability of transport for clients reduces 'no shows', which improves client outcomes and increases organisational efficiencies.

Co-locating the multidisciplinary team(s) may require re-organising clinic/health service layout, but is unlikely to incur substantial additional costs, assuming team members have already had a role and place in the organisation.

See module 10 for additional discussion of co-location for delivering integrated AOD care.

(b) IT systems

The clinical information system (CIS, for example, Communicare) plays a critical role in supporting integrated care delivery. The CIS supports record sharing between practitioners, and enables team members and the organisation to monitor, report and assess progress of individual clients, programs and the organisation as a whole.

The CIS provides a mechanism to deal with the complexity of multiple funding streams, and can reduce the pressure on front-line staff.

Congress estimates that up to four weeks work was required to adjust its clinical information system (Communicare) to enable it to monitor and report about delivering AOD care. Because of Congress' in-house CIS expertise and capability, other organisations which are starting to enable information sharing between SEWB and medical functions including for AOD, may need to factor in greater amounts of time and resources required.

See module 9 for more detailed discussion of information sharing requirements for integrated AOD care.

8.2 Income sources

This section identifies some income sources which may support organisations to invest in the systemic changes required to provide integrated care for AOD clients. Funding programs change over time, so the information and links provided in this section which were current at December 2018, may be out of date.

NACCHO affiliates may also be able to assist health service providers to identify potential funding sources.

8.1.1 Australian Government funding

Aboriginal community controlled health organisations are primarily funded through the Commonwealth Department of Health under the Indigenous Australians' Health Program, Primary Health Care Activity. However, funding from the Primary Health Care Activity is not available for social and emotional wellbeing counsellors or specialised drug and alcohol support services. Funding for SEWB and AOD services may be available from the Department of the Prime Minister and Cabinet under the Indigenous Advancement Strategy, Safety and Wellbeing Programme [50].

Australian Government Department of Health funding programs include:

- Drug and Alcohol Program [51]. The program will fund capacity building activities with the purpose of strengthening the drug and alcohol sector to improve service outcomes and reduce the impact of drug and alcohol misuse.
- Primary Health Networks (PHNs) [52]. Includes the Aboriginal and Torres Strait Islander Mental Health Services; ATAPS (Access to Allied Psychological Services)
- MBS Better Access to mental health care which aims to provides better access to mental health practitioners through Medicare [53].

  Medicare rebates under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative are available for patients with a mental disorder to receive up to ten individual and up to ten group allied mental health services per calendar year. At the conclusion of each course of treatment, the allied mental health professional must report back to the referring medical practitioner on the patient's progress and the referring practitioner assesses the patient's need for further services [54].

  All patients require a current Mental Health Treatment Plan (MHTP) for rebates under Better Access services from Medicare. See Figure 13 for the relevant MBS item numbers.

Medicare rebates provide AOD (and other mental health) service providers with an untied source of revenue. Congress anticipates that rebates could contribute up to 10% of its overall SEWB program budget. It is up to a service provider how it reinvests the untied funds, including the extent to which funds are hypothecated to the program generating them.

A focus on supplementing organisational grant revenue with income from Medicare rebates is not without risks: some staff may see it as advantaging the western medical model over more culturally appropriate practices, reinforcing power differentials in favour of medical/psychological staff. Action to reduce the power differentials between different

professions within the multidisciplinary team are therefore particularly important (see Module 6).

Given the additional time and effort involved, staff with the capacity to apply for Medicare rebates may need to be persuaded to do so based on the benefits accruing from additional untied income, as their salaries are underpinned by grant funding. Congress has found regular weekly monitoring through the clinical information system, and conversations between managers and practitioners has increased the likelihood that practitioners will apply for Medicare rebates.

Figure 13: MBS items for Better Access rebates [54]

There are 32 MBS items for allied mental health services provided on referral by a GP, psychiatrist or paediatrician:

- Items 80000, 80005, 80010 and 80015 – Individual Psychological Therapy services provided by a **clinical psychologist**
- Item 80020 – Group Psychological Therapy Services provided by a **clinical psychologist**
- Items 80100, 80105, 80110 and 80115 – Individual Focussed Psychological Strategies services provided by a **registered psychologist**
- Item 80120 – Group Focussed Psychological Strategies services provided by a **registered psychologist**
- Items 80125, 80130, 80135 and 80140 – Individual Focussed Psychological Strategies services provided by an eligible **occupational therapist**
- Item 80145 – Group Focussed Psychological Strategies Services provided by an eligible **occupational therapist**
- Items 80150, 80155, 80160 and 80165 – Individual Focussed Psychological Strategies services provided by an eligible **social worker**
- Item 80170 – Group Focussed Psychological Strategies services provided by an eligible **social worker**

From 1 November 2017, the following items are available 80001, 80011, 80021, 80101, 80111, 80121, 80126, 80136, 80146, 80151, 80161 and 80171 and each specify the requirements the service must satisfy in order to be Medicare-eligible for telehealth psychological therapy and focussed psychological strategies

8.2.2 State and Territory funding

State and Territory governments are key investors in AOD services, and often have programs aimed at facilitating and improving coordinated/integrated care.

Organisations seeking funding to improve delivery of AOD services can discuss their intentions with their jurisdictional health department.

Examples of relevant programs include:

- NSW Health AOD Programs
- Integrated care in NSW
- Health.Vic AOD Programs

- Health.Vic Mental Health Demonstration Projects
- Queensland Health AOD Services
- Queensland Integrated care innovation fund
- WA Mental Health Commission
- NT Remote AOD Workforce Program

State and Territory peak AOD organisations may also be able to provide guidance about potential funding sources:

- NSW Network of Alcohol and other Drug Agencies (NADA)
- Victorian Alcohol and Drug Association (VAADA)
- Queensland Network of Alcohol and other Drug Agencies (QNADA)
- WA Network of Alcohol and other Drug Agencies (WANADA)
- SA Network of Drug and Alcohol Services (SANDAS)
- Association of Alcohol and other Drug Agencies NT (AADANT)

9 Information sharing for integrated AOD care

Objective: to provide a guide to the sharing of client care information to underpin effective integrated AOD care for Aboriginal and Torres Strait Islander people.

The multidisciplinary approach to the care of AOD clients rests upon shared input into and access to client care information across the multidisciplinary team.

Optimally, all care is coordinated through the organisation's Clinical Information System. This allows one record and care plan per client, shared by the staff across disciplines, to give a holistic picture of the client's needs and to support multidisciplinary care. This shared information system enables a focus on good clinical governance, and a Continuous Quality Improvement (CQI) approach to monitoring, evaluating, and adapting the care system for AOD and other SEWB clients.

However, information sharing must be consistent with ethical, legal and organisational requirements, including [55]:

- ensuring client confidentiality,
- having valid, informed consent from the client, and
- complying with legal requirements for recordkeeping, storage and release of client information.

This module contains the following sections:

9.1 Informed consent

There are two consent forms which Congress uses during the initial assessment phase of service delivery:

1. **Consent to engage in the service**: this consent form is used in the first session/engagement that a worker has with a client. It requires that the worker explains how client confidentiality is protected and the limitations of confidentiality if the client chooses to engage.
2. **Consent to release information:** this consent form is used to gain clients' consent to discuss specified information with identified service providers, agencies and other individuals. This is to be used as necessary.

See Appendix to this Module for sample so these forms.

9.2 Sharing clinical data

> ***Integration of care may be compromised if a provider in one program cannot determine if a patient has followed through with a referral, or if a patient has a health condition that is related to, could be exacerbated by, or requires medication which is contraindicated with AOD use. Moreover, these regulations and practices can serve to reinforce the stigma associated with AOD and mental health problems.***
>
> *Sterling S, Chi F, and Hinman A, Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions*

9.2.1 Rationale

Protecting the confidentiality of clinical information, especially as it relates to SEWB and AOD use, and ensuring that it is only accessed by those who are authorised to do so, is a foundation for good care. It is particularly so in the sensitive area of AOD / SEWB services and in the context where some Aboriginal and Torres Strait Islander people may be concerned about how such information may be used (for example, in the context of child welfare).

Integrated multidisciplinary care for clients with AOD issues requires the sharing of clinical information amongst those sharing the care of the client. This can be a challenge for service providers as some staff may not previously have had the experience of working as part of a multidisciplinary team (as opposed to being a sole provider of care). In addition, some professions (for example, psychology) have standard practices that preclude sharing client information with other practitioners. The benefits of carefully proscribed sharing of clinical information for AOD clients include:

- **it underpins holistic care for the client**, ensuring that all members of the team are able to take account of their needs and reducing the client's experience of having to 'repeat their story' numerous times to different providers,
- **it reduces risk to both the client and the practitioner**, for example by ensuring that all members of the care team are aware of a client's medical, social, or psychological issues, and
- **it maximises accountability for care provided** and on progress on treatment goals.

9.2.2 Using a Client Information System to share information

Client Information Systems (CIS) are a powerful tool for enabling integrated, multidisciplinary care. However, it is important that:

- **Clients give informed consent** for the sharing of their information with other members of the care team,
- **Client Information Systems are appropriately adapted to support integrated care,** for example by creating clinical screens or items for inputting, accessing and reporting on particular issues for AOD clients (for example, results of screening assessments). This may have up-front and on-going resource implications – see Module 8),
- **Staff are supported in the consistent use of the CIS**, for example through orientation processes, ongoing training, and the provision of written policies and manuals,

- **Access is strictly regulated**, through setting of a tiered system of permissions for members of the care team to restrict access to some types of information where absolutely required, and through audits/ alerts of unauthorised access to client information. Unauthorised access may be considered a breach of confidentiality and dealt with as such under the organisation's policies and procedures, and
- **Formal training in 'Confidentiality' for staff** may be provided at commencement of employment and increased promotion of the 'no tolerance' confidentiality policy.

9.2.3 CIS Permission Levels

Some Client Information Systems (for example, Communicare) have various tiers of information protections. This includes preventing some categories of staff from seeing certain information if they are not at the designated permissions level.

User permission levels should be determined by role and the need to know information to be able to undertake their role in caring for the client. This will primarily be determined by Australian Health Practitioner Regulation Agency (AHPRA)registration and requirements of role as defined by the user's position description.

This system and the permission levels may need to be set up but may include the following rules which are in place at Congress.

- As professionals, staff should not access a client's file without a valid reason. All staff members are audited by CQI for inappropriate access and a monthly report is generated. Unless a valid reason is provided, staff that inappropriately access files will face disciplinary action.
- As a basic rule leave the permission level as General.
- If the clinical item has general permission, anyone with general access can see it even if in a highly sensitive case note.
- Highly sensitive and/or psychological offers the most protection – but this is double edged – if an important risk issue is in there and it isn't assessable to someone involved in care this can be a problem.

9.2.4 Routine information sharing with other organisations

Sharing client care information across service providers is critical for effective integrated care approaches.

In remote areas and also in mainstream health systems, the full suite of holistic care services required by clients may be provided by a number of organisations, rather than a single health provider. In these cases, information sharing to support integration will need to cross organisational boundaries.

In all settings, information sharing with other types of service – for example, hospital inpatient care or residential treatment services enhances client care.

Sharing client care information across collaborating service providers:

- must be founded on systems for gaining client consent for information sharing

- should be formalised through establishing Memoranda of Understanding (MOUs) that establish clear guidelines and safeguards around the use, disclosure, and protection of client care information
- should include shared access to treatment plans, case conference notes and other information to support a common approach to treatment
- can be facilitated by shared access to electronic Client Information Systems
- can be enhanced by formalised meeting and arrangements and/or co-location of service programs and staff (see also Module 6 Effective Multidisciplinary Teams).

9.3 External requests for client information

Services may receive requests for client information from various sources, most commonly from other service providers who are also providing care to a client. Such requests may be made in writing by a letter, or emailed, or made verbally over the phone.

There may be times when other agencies do not have the appropriate authority to gain such information, so it is important that staff do not feel pressured to respond without consulting their managers.

All such requests should be discussed with senior staff to establish:

- whether the service provider is legally obligated to disclose the information,
- whether the service provider is ethically obligated to disclose the information for example where there a client may be at risk of self-harm or of harming others,
- what information needs to be disclosed, what does not and what needs redacting, and
- whether an appropriate level of consent that has been provided.

9.4 Mandatory reporting

All jurisdictions in Australia have laws requiring the mandatory reporting of child abuse or neglect. In some jurisdictions (for example the Northern Territory) there is also a legal obligation to report domestic and family violence. Managers should be familiar with all current mandatory reporting requirements and orient and update staff regularly on these.

It is good practice for staff to discuss any potential cases requiring a mandatory report with senior staff. It is legally and ethically acceptable to seek supervision as soon as practicably possible before making the decision to report.

For more information

- Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions (Sterling, Chi, and Hinman, 2011)
- Case Management in Non-Government Alcohol and Other Drug Services: a practical toolkit, Association of Alcohol and Other Drug Agencies of the NT, 2015

Appendix: Sample consent forms

- **[LINK TO COPIES OF THE TWO FORMS]**

10 Co-location and outreach

Objective: to provide information on co-location and outreach to support effective integrated AOD care for Aboriginal and Torres Strait Islander people

Outcomes for clients can be improved by co-locating the members of the multidisciplinary AOD team, and by providing outreach (off-site) services.

This module contains the following sections:

10.1 Co-location of services

Co-locating the members of the multidisciplinary team at a single site is an effective way of improving integrated care for AOD clients.

Benefits include:

- Less chance that other clients can identify what issues are being addressed, reducing stigma and therefore encouraging clients to access AOD services
- Increasing opportunities for 'warm referrals' across the multidisciplinary team. Personal introductions to other team members at the time of initial contact/assessment, and the possibility of immediate interactions or sessions can build the client's trust and confidence in the service providers. The time between referral and treatment can be reduced, which also improves the potential that the client will engage with the service.
- Improving collaboration between members of the care team. Care team members are more likely to have face-to-face discussions about client care, and gain a better understanding about a client's needs. This flows on to better care for the client.

Specific rooms within the primary health care service should be designated for counselling, and be fitted and furnished in client friendly ways aimed at assisting them to relax, rather than as clinical spaces.

In addition, health service providers have found it important to have a safe space to have difficult conversations between team members who have different skills and perspectives.

Where co-location coincides with decentralisation of health service provision (eg outlying clinics), the program coordinator may need to make extra effort to connect teams across sites.

10.2 Outreach and client transport

Systems of outreach and client transport are critical elements for effective integrated AOD care.

Client outreach – authorising staff to leave the clinic and to support clients in environments where the client feels most comfortable – is an essential component of the 3 streams of care model. Client outreach:

- allows clients to interact with the service on their own terms, increasing the likelihood of continued and positive engagement with the service
- enables team members to assist clients in practical ways such as liaising and advocating with other service providers (for example, Centrelink, housing, justice), which are key to reducing stressors
- improves team member understanding of the situation surrounding clients (their families) and their needs.

Providing transport to and from the health service provider, and to other appointments that are part of a client's care plan increases the opportunities for positive engagement and effective care for the client. Health service providers operate their transport services in different ways: bus services, individual vehicles, subsidized commercial transport.

A strong emphasis on outreach requires consideration of different risks to staff/clients than those arising in a clinic/health service environment. These risks should be assessed and mitigated so that staff and client safety is paramount. See *Appendix* for a risk assessment checklist and tool for assessing risks of off-site activity adapted from Congress and Mallee District Aboriginal Services.

Appendix: Off-Site Activity Risk Assessment

OFF-SITE ACTIVITY RISK ASSESSMENT CHECKLIST		
Find out as much as possible about the following points from the client, referral source, medical records and/or 3rd parties. If unable to ascertain relevant information tick 'unknown'.		
Date of Assessment	**Initial /Review (Circle applicable)**	
Client Name		
HRN /DOB		
Address		
Risk factors	**Comment**	**Level of Risk**
1. Client / household history of violence or aggressive behaviour		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
2. History of substance abuse. Intoxicated		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
3. Threatening, argumentative behaviour Resistance to care		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
4. Occupants with infectious illnesses		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
5. Neighbourhood security risks eg - Difficulty locating property - House obscured by fences/trees - Gate difficult to open - Shared driveway - Difficulty seeing main door from road - Unreliable mobile phone reception - Insufficient lighting		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
6. Travel issues e.g. State of roads, weather alerts, road closures due to ceremony		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely
7. Other e.g. aggressive/ unrestrained animals Feeling unsafe on your own		☐ Very Likely ☐ Likely ☐ Unknown ☐ Unlikely ☐ Highly Unlikely

Risk identified or unknown risk - minimum TWO people MUST attend home visit / off-site activity. Refer to Risk Assessment Tool and ensure appropriate Controls are implemented			
Person Completing Checklist	NAME	SIGN	DATE
Manager / Supervisor	NAME	SIGN	DATE
Additional Comments			

Assessment	Risk Level	Safety Action
A serious safety issue exists in providing service. For example: the patient/client or significant other has initiated physical aggression against an individual or persons including workers and has been identified as a threat to continuance of safe service delivery; very difficult access; limited/no communication access (mobile phone/satellite phone); very unsafe location	**Very High Severity SR4**	➡ Management plan must be developed and/or service cessation plans initiated should the need arise. ➡ Service provision is not to be provided off-site i.e. to be provided in a clinic/health service with minimum 2 workers and added security measures (e.g. police, reliable community member/s, other workers) present ➡ If service is required in a remote or isolated location with limited communication access, the service team must have identified roles for team members and verified safe options, including cessation or withdrawal of services. ➡ An emergency plan must be in place before client interaction takes place off-site.
A significant safety issue exists in providing service. For example the patient/client or significant other has threatened an individual and/or persons including workers with personal and or physical harm, or difficult access, or known aggressive/uncontrolled pets, or unsafe location	High Severity SR3	➡ Service delivery by minimum two workers with an identified process, assessed to achieve safe service provision and maintain patient /client and workers wellbeing. ➡ If service required in a remote location, an emergency plan must be in place before client interaction takes place including ability to summon assistance quickly if required (e.g. reliable community member/police/other workers)
A potential or unknown safety issue exists in providing service. For example the patient/client or significant other has intimidated and or been verbally aggressive to other and/or workers, or difficulty in access, or unsafe location	Medium Severity SR2	➡ Ensure appropriate controls are in place before providing service due to previously assessed risks. ➡ Review clients file and identify risks and controls - if any doubt exists as to the level of safety in providing the service, minimum 2 workers must attend or ask client to attend a clinic for service.

No potential safety issues identified relating to: behaviour, locality, access (or other), manual handling have been identified. Providing service to this Patient / Client represents very low/minimum known risk potential to all persons.	Low Severity SR1	Initiate interaction and or service provision normally. Follow standard service provision protocols.

11 Measuring change and reporting service effectiveness

Objective: To enable health planners/managers to monitor and assess what changes are occurring as a result of adopting the three streams approach to AOD service delivery.

Evidence about outcomes is an important driver of improved service delivery. Monitoring and evaluation is the systematic assessment of the process and / or outcomes of a project or program, compared to a set of explicit or implicit standards [56]. By conducting monitoring and evaluation we can [57]:

- Learn from our actions
- Tell people about what we have done and achieved
- Share what's been learnt with others
- Help plan for the future
- Improve our services and interventions
- Be accountable to funding bodies, managers, communities and ourselves.

Goals, indicators and monitoring arrangements should be built into AOD services as part of change planning and implementation. This allows managers and staff to track and learn from the change processes in order to reflect and improve.

Collectively establishing goals and objectives is an important part of managing the change to the three streams approach. Similarly, participatory design of the M&E system will increase the likelihood that team members collect relevant data and use it to inform their practice.

Collection and reporting of data requires resources, has opportunity costs and may require new information and communication mechanisms. It is aided by common patient identifiers and electronic health records [37].

It is assumed that health planners/managers understand the importance of measuring the impact of adopting new service approaches; and are familiar with how to plan monitoring and evaluations.

This module contains:

11.1 Monitoring and evaluating integrated AOD programs

Monitoring measures progress toward results by collecting information on inputs, activities, outputs and short-term outcomes. It assists in managing program implementation [56]. Reporting requirements for SEWB funding – for example through the Online Services Report (OSR) – tend to be focussed on inputs and outputs such as staffing, counts of services are provided, clients, client contacts, and episodes of care.

Evaluation assesses the effectiveness of efforts to improve services and health. It measures the extent to which desired results are achieved, and helps to understand why results were or were not achieved [56].

To maximise opportunities for continual learning and improvement, the monitoring and evaluation decisions should be made as part of program establishment and rolled out as an integral part of program implementation.

Evaluation of AOD programs servicing Aboriginal and Torres Strait Islander people needs to be undertaken in ways that ensure that Indigenous stakeholders (individuals, organisations, communities) are involved throughout the evaluation process [47]. Evaluations should:

- Involve the community
- Occur from the initial development of programs
- Provide adequate funding for monitoring and evaluation and
- Include a range of methods
- Reflect other strategies that are in place to address Aboriginal and Torres Strait Islander wellbeing.

Involving frontline team members in participatory evaluations will increase their understanding of the program and support improvements [57].

As a rule of thumb, evaluations cost in the order of 10% of the operating costs of a program.

Evaluating the Individual Treatment Plans includes gathering and analysis of information regarding the strategies, resources, interventions or services (as well as their cost-effectiveness) and their ability to meet the desired treatment goals or outcomes. Client satisfaction and feedback in this instance should be at the forefront of any evaluation, as should feedback from any services you worked with.

It is highly recommended that a client's treatment journey is collectively reflected upon by the multidisciplinary team involved in the treatment plan. Considering case management is essentially a collaborative process, it therefore makes more sense to reflect on our practices for future quality management as a bigger team of professionals

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Evaluations need to be conducted systematically and rigorously, using appropriate methods of data collection which address clearly defined program goals and objectives.

11.1.1 Deciding on the types of indicators to be used to measure service effectiveness [57]

Indicators may be:

- *outcome* indicators – identify the information needed to assess the degree to which the longer term goal has been achieved
- *impact* indicators – identify the information needed to assess the degree to which the objectives have been achieved
- *process* indicators – identify the information needed to assess effectiveness of the strategies.

Each indicator should:

- be clear, precise and measurable
- focus on a specific aspect of the strategy or objective

- generate specific questions that can be practically addressed (ie data to answer the questions should be available and accessible).

Impact and outcome indicators both relate to the extent to which the program achieves its objectives and goal(s). They make take some time to come to fruition. They relate to issues such as:

- Changes in awareness, knowledge and skills
- Increases in numbers of people reached
- Changes in behaviour
- Changes in community capacity
- Changes in organisational capacity
- Increases in service usage
- Improved continuity of care
- Improvement in health status indicators
- Policy or changes to the entire system.

Impact/outcome indicators can address changes in relationships between organisations to measure systemic change:

- How have the relationships between participants changed as a result of their participation
- How have policies/practices changed
- Have any new strategies, plans, collaborations evolved as a result of the program?
- How will changed relationships be supported in future and what is needed to do this?

Process indicators address the quality of what has been done "how well are we doing?"

- Has the program been conducted according to plan
- Have there been any changes, and what were the reasons for change?
- What was the reach and scope of the program?
- What was the quality of the program?

11.1.2 Deciding on the data collection methods [57]

When considering which data collection methods to use, it is important to consider:

- the cost of applying the method and analysing the data
- whether technical assistance is required to gather and analyse the data
- If the method will fully address the indicators, and if not whether additional or alternative methods should be used
- if there are any potential problems that applying the method will create in relation to the accuracy, validity, and reliability of the information obtained about the program
- if the data can be readily gathered systematically as part of the program by those involved in its delivery.

11.1.3 Performance indicators identified in the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019 [13]

The National Aboriginal and Torres Strait Islander Peoples' Drug Strategy identifies

intended outcomes and suggested actions for reducing:

- the proportion of people consuming alcohol at risky levels.
- levels of illicit and licit drug use
- AOD-related offending and involvement in the criminal justice system.
- the proportion of people smoking tobacco
- blood-borne viral infections due to injecting drug use .

Priority area 4 of the Strategy emphasises the importance of establishing meaningful performance measures and effective data systems that can support community-led monitoring and evaluation.

Outcome 4.1 Performance measures reflect meaningful outcomes aimed at the individual, family and community.

Example actions

- Link performance measures to locally identified need.
- Support community leadership in the development of performance measures.
- Develop performance measures that span across individual, family and community outcomes.
- Ensure monitoring is linked to performance measures.

Outcome 4.2 Data systems and quality assurance programs are in place to inform investment in sustainable program delivery

Examples of actions that could be applied as part of the three-stream model include:

- Collecting data in accordance with best practice guidelines for collecting Aboriginal and Torres Strait Islander status in health data sets, with a particular emphasis on the design of relevant questions and custodianship of data in relation to control, access, ownership and usage.
- Supporting efforts to improve the quality of administrative data and, where possible analyse these data sets and disseminate information and statistics.
- Enhancing existing data sets and planning models to support transparent, consistent and evidence-based health planning that is appropriate for AOD services in Aboriginal and Torres Strait Islander community-controlled health organisations.
- Collecting data in a manner that is consistent with the Alcohol and Other Drug Treatment Services National Minimum Data Set.
- Implementing programs that align with relevant quality frameworks for continuous improvement.

Examples of the types of performance indicators that could be used to demonstrate progress for each priority area are listed below [13].

- Access of Aboriginal and Torres Strait Islander people to AOD programs, measured by awareness, convenience, availability, affordability, cultural safety and respect.

- Community devised measures are identified in local level initiatives.
- Client satisfaction with treatment.
- Number and success of community-driven and community-accountable prevention programs, for example alcohol management strategies.
- Proportion of AOD and Social and Emotional Wellbeing services delivered by community-controlled organisations.
- Inclusion of cultural competencies within the range of organisations that interact with AOD clients.
- Formal agreements between agencies to coordinate service provision.
- Implementation of joint case management strategies.
- Engagement in different types of drug treatment and treatment completion.
- Provision of after care services.
- Number of services undertaking continuous quality improvement.
- Number of formally accredited AOD services.
- Number and success of culturally and community-focused diversionary programs available to Aboriginal and Torres Strait Islander people, and particularly young Aboriginal and Torres Strait Islander people.
- Number of through-care programs in correctional and juvenile detention centres.
- Referral of offenders whose offences are AOD-related to treatment, for example counselling services or residential rehabilitation diversion programs and culturally appropriate AOD services within prisons.
- Dispensing of free nicotine replacement treatments.
- Access to needle and syringe exchange programs (both in mainstream and community-controlled organisations).
- Access to pharmacotherapies.
- Number of Aboriginal and Torres Strait Islander people on opioid replacement therapy and referred from harm reduction services to general and mental health services and other social and welfare support services.
- Access to low aromatic fuel in regions at risk of petrol-sniffing.

11.2 Example of performance measures

Examples of key indicators that Central Australian Aboriginal Congress is using to measure success of their three-stream AOD care program include:

- At each contact with clients (potentially weekly), record in the patient information system:
    - Responses to AUDIT-C questions about the client's current use of alcohol
    - Responses to Kessler-5 (K-5) questions to gauge mental distress
    - Responses to DUDIT/DUDIT-4 questions about the client's current use of drugs

- Apply and record Here and Now Aboriginal Assessment (HANAA) [58] social and emotional wellbeing domains in the patient information system at the first and last therapy sessions.

The full list of information gathered and used by the CAAC SEWB Manager can be found below.

For more information

- Managing Information: monitoring and evaluation, LeMay N., 2010 Ch 9 in Management Sciences for Health, *Health Systems in Action: an eHandbook for Leaders and Managers*
- Evaluating AOD Projects and Programs. Module 4, Aylward, P. 2005. in N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, & C. Todd (Eds.), *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field*. NCETA, Flinders University, Adelaide, Australia.
- National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 - 2019, Intergovernmental Committee on Drugs
- NSW Minimum Data Set (MDS) for drug and alcohol treatment services
- The NSW MDS DATS consists of over forty data elements collected by the organisation throughout the course of a treatment episode with a client. The data types include administrative elements about the agency providing services, as well as elements about client demographics, client drug use and the services provided. The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS), collected across all Australian states and territories, is a subset of the NSW MDS DATS. Data from the MDS DATS can be used locally by organisations to better understand the clients accessing services and the services provided, as well as for broader system planning and policy development.

Appendix: Congress list of measures/indicators

Goal: to reduce harm related to alcohol and other drugs among Aboriginal and Torres Strait Islander people through an integrated, 3 streams of care system

Objective 1: Accessible service

What are we trying to achieve? (Objective)	To provide an accessible Social and Emotional Wellbeing service of high quality for Aboriginal clients living in and visiting our health service area including remote communities in which we provide health services
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	increasing the number of referrals from internal services 1.2 Increasing the number of referrals from external service providers 1.3 Increasing the number of self-referrals. 1.4 Ensure clients are contacted within 1 week of allocation.
When will we achieve it by? (Timelines)	This is an ongoing process Over the next 3 months, we will discuss with internal services how we can develop a group program on site to target their clientele for high risk issues (i.e. drinking while pregnant).
KPIs	1.1 Unique clients and episodes of care 1.2 Contacts by speciality type medical, psychological, social worker, AOD worker, youth workers 1.3 Age breakdown of clients 1.4 Type of clients (MH, VIP, AOD, Neuro, Soc/Cultural) 1.5 Referrals: Breakdown of referrals from internal services (services, type of referral, age, gender, MH, AOD, etc..). Breakdown of referrals from external service providers (services, type of referral, age, gender MH, AOD, etc..). Self- referrals to the AOD service. (age, gender, type of referral MH, AOD, etc..). 1.6 Response time from referral to allocation to first initial contact + Non-contactable clients
What are we trying to achieve? (objective)	To provide Social and Emotional Wellbeing Services to our remote area sites

Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker Remote AOD staff All other staff
How will we achieve it? (Actions)	2.1 Increasing the number of referrals to our remote teams Currently our remote teams provide AOD brief intervention and group psychoeducation to client. The number of referrals for individual therapy need to be improved. Increasing the access to psychologists in our remote sites through exploration of available resources and models.
When will we achieve it by? (Timelines)	Continue to strengthen our referral pathways and connect with other services in the remote sites to promote our service and what we can offer. Engage in promotional activities. Continue to send psychologists to remote sites to work with referred clients on a range of issues. When face-to-face sessions are not possible, the use of tele-psych technologies will be utilised.
KPIs	2.1 – Breakdown of referrals from remote sites (gender, type, source) 2.2 – Remote Therapeutic Interventions by type and month (including AOD brief interventions, social support, advocacy, cultural support, transport) 2.3 – Psychologist Client Contacts and Remote AOD worker contacts by community

Objective 2 – Increasing remote services

What are we trying to achieve? (objective)	To provide Social and Emotional Wellbeing Services to our remote area sites
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker Remote AOD staff All other staff
How will we achieve it? (Actions)	2.1 Increasing the number of referrals to our remote teams Currently our remote teams provide AOD brief intervention and group psychoeducation to client. The number of referrals for individual therapy need to be improved. Increasing the access to psychologists in our remote sites through exploration of available resources and models.

When will we achieve it by? (Timelines)	Continue to strengthen our referral pathways and connect with other service providers in the remote sites to promote our SEWB service and what we can offer. Engage in promotional activities. Continue to send psychologists to remote sites to work with referred clients on a range of issues. When face-to-face sessions are not possible, the use of tele-psych technologies will be utilised.
KPIs	2.1 – Breakdown of referrals from remote sites (gender, type, source) 2.2 – Remote Therapeutic Interventions by type and month (including AOD brief interventions, social support, advocacy, cultural support, transport) 2.3 – Psychologist Client Contacts and Remote AOD worker contacts by community

Objective 3 – Efficient and Effective Clinical Services

What are we trying to achieve? (objective)	Efficient and effective clinical services
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	3.1 Ensuring the three streams of care are followed for each client through the development of care plans. Weekly review meetings provide an avenue for care plan review allowing the addition of therapists to client cases to provide therapeutic intervention.
When will we achieve it by? (Timelines)	3.1 Currently review teams in SEWB are working through the current client load ensuring all client assessments and care plans including risk management plans are developed so that all disciplines can provide holistic support to each client.
KPIs	3.1 SEWB Therapeutic Interventions by type and month (including AOD brief interventions 3.2 Average therapeutic interventions per unique client by type and month 3.3 Contacts per encounter mode 3.4 Client did not attend appointment by month by practitioner type 3.5 Client contact outreach unsuccessful per month

Objective 4 – Engage clients in Social, Cultural Advocacy Support and Case Management

What are we trying to achieve? (objective)	Engage clients in social, cultural, advocacy support and case management

Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	4.1 Continue to provide a high level of social support to clients through the assigning of AOD care managers to the client. 4.2 Continue to provide a high level of advocacy support to clients through the assigning of AOD care managers to the client. 4.3 Continue to provide a high level of cultural support to clients through the assigning of AOD care managers +to the client. 4.4 Continue to provide transport to clients when necessary. 4.5 Facilitate client accessing three streams of care
When will we achieve it by? (Timelines)	This is ongoing but through the use of the new initial assessment and weekly review meeting discussions we foresee better allocation of resources to meet client needs in a holistic approach.
KPIs	4.1 Monthly breakdown of social support 4.2 Monthly breakdown of advocacy 4.3 Monthly breakdown of cultural support. 4.4 Monthly breakdown of transport 4.5 (Table) Support type, number of sessions, number of unique clients, number of session of support per unique client. 4.6 – Monthly breakdown of clients + their primary diagnosis who have access to both social/cultural stream + therapeutic stream

Objective 5 – Increasing Medicare and ATAPs

What are we trying to achieve? (objective)	To increase Medicare revenue and provide ATAPs services and increase Medicare referrals
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	5.1 Through communication with internal services discussing referral pathways and the importance of referral with a mental health treatment plan. 5.2 For clients who have presented to SEWB for therapy who do not have a mental health treatment plan, practicing the three streams of care through referring to the SEWB GP for review and development of MHTP. 5.3 Continue to treat clients under ATAPs when appropriate and examine other opportunities to increase ATAPs funding.

When will we achieve it by? (Timelines)	Ongoing. Recently have discussed with GPs regarding importance of referring with a MHTP. Discuss with GPs their barriers to referring with MHTP. Over the next 3 months, to explore with PHN the potential for additional funding from ATAPs eg through the Suicide prevention ATAPS program.
KPIs	ATAPs, Therapist Medicare, GP medicare over last few years 5.1 Number of referrals with a MHTP 5.2 Number of MHTP completed by SEWB doctor 5.3 Number of clients seen under ATAPS, sessions per client. 5.4 Medicare claiming by practitioner type 5.5 Proportion of SEWB psychologist clients on a MHTP

Objective 6 – Conducting appropriate assessment and measures.

What are we trying to achieve? (objective)	To conduct appropriate assessments and utilise appropriate measures of change across our primary client groups
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	Ongoing review of assessment and outcome measures are necessary to ensure appropriate assessment and measurement of client baseline and progress. This includes a measure of drug use, better mental health outcome measure, and a measure for violence. 6.1 Ensure all staff are completing their initial assessments through ongoing education and through the client review process. 6.2 Ensure staff working with clients with alcohol issues utilise ongoing outcome measures (Audit-C, K5, TLFB) at appropriate intervals 6.3 Ensure all staff are completing K5 as an initial indicator of client stress + follow-up. 6.4 Ensure clients with other addictions receive TLFB and K5 6.5 Ensure psychologists are utilising their specialist skill set through the use of psychometric assessments (i.e. mental health, personality, cognitive).
When will we achieve it by? (Timelines)	The research and implementation of new measures will be achieved over the next 3 months. Ongoing education for staff to ensure use of these measures. The weekly review meetings will also provide an avenue of reinforcing assessment and measurement data.

KPIs	6.1 Number of assessments conducted 6.2 Number of Audit-c (per month), Number of timeline follow backs (per month) 6.3 Number of K5 (per month) 6.4 Number of psychometric testing (per month, per type) 6.5 Proportion of clients with two or more outcome measures while in treatment with SEWB who showed significant change over time

Objective 7 – Client reviews

What are we trying to achieve? (objective)	Appropriate review of clients and management of client safety through conducting appropriate risk assessments, care plans and engage in client reviews
Who is trying to achieve it? (Sections/Positions)	Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	7.1 Ensure risk reviews are being conducted with all clients upon initial presentations 7.2 Ensure clients who have been found to have risk factors receive ongoing risk reviews. 7.3 Ensure all active clients are reviewed after entry with development of appropriate careplans. 7.4 Ensure all active clients have a follow-up review where possible (I.e prior to exit) 7.5 Ensure all active clients have a care plan developed as part of their treatment
When will we achieve it by? (Timelines)	This will be an ongoing process. Risk reviews will be ongoing.
Comments	7.1 Risk Assessments and Risk Management Plans executed during client's episode of care. 7.2 The proportion of unique clients with a risk assessment 7.3 No of unique clients reviewed per month 7.4 No of clients who have had follow-up review. 7.5 No of clients with careplans (+ updated care plans).

Objective Goal 8 – Client load management

What are we trying to achieve? (objective)	To appropriately manage client loads and client exits from the program.

Who is trying to achieve it? (Sections/Positions)	Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	Client loads must be within a manageable level in order to ensure that clients receive adequate care. Review meeting process to identify clients who no longer require our support Analyse client disengagement Through supervision, team members will manage their client loads to be at an appropriate level to ensure that clinical governance is maintained. Analysis of attendance data to develop a more appropriate measure of client load management over purely caseload number.
When will we achieve it by? (Timelines)	This is an ongoing process with weekly meetings assisting in the management of this issue.
KPIs	8.1 Table of reasons for client closure by client per month 8.2 Number of clients who only attended one session before not attending again and being closed – by gender, per month 8.3 Length of average time in treatment (from referral to discharge) by client type (AOD, MH, VIP etc..), gender and age range. 8.4 Average client load per profession type (monthly breakdown)

Objective 9 – Staffing, training and professional development

What are we trying to achieve? (objective)	To maintain appropriate staffing levels and have staff engaged in appropriate training.
Who is trying to achieve it? (Sections/Positions)	SEWB Manager Snr Clinical Psychologist Snr Social Worker All staff
How will we achieve it? (Actions)	9.1 Maintaining appropriate staffing levels across the professions is important in order to provide an adequate service. 9.2 Exploration of the impact of unfilled positions and staff leave on service delivery to ensure appropriate management of staff leave. 9.3 In terms of staff training, ongoing support, access to education and providing leave to attend professional development opportunities assists in the development of our workforce.
When will we achieve it by? (Timelines)	Ongoing.

KPIs	9.1 Monthly breakdown of staffing levels + positions vacant by profession. 9.2 Monthly breakdown of staff on leave, by profession 9.3 Staff training completed (type by profession) 9.4 Staff professional development attended (type by profession)

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