



Evaluation of the NSW Aboriginal Mental Health Worker Training Program

FINAL REPORT EXECUTIVE
SUMMARY

Mental Health and Drug and Alcohol
Office, NSW Ministry of Health

August 2013

Acknowledgments

We would like to thank the many participants in the evaluation—key stakeholders who participated in interviews, Program trainees and graduates and other LHD mental health service staff who were interviewed during site visits or by telephone, and mental health service staff who completed the online survey. We thank them for their time and insights and trust that their views are adequately represented in this report.

We would especially like to thank our LHD mental health service key contacts who helped us organise the site visits and set up the interviews with mental health service staff involved in the Program. We would also like to acknowledge the Evaluation Reference Group that provided advice and direction during the project: Regina Osten/Lynelle Richards, Kristen Ella, Barry Kinnaird, Glen Williams, Tom Brideson, Linda Carroll, Denver Simonz, Leanne Scholes-Asper.

We are grateful for the support provided by Tom Brideson (Statewide Program Coordinator) and Robyn Owens (Administrative Assistant) during the evaluation.

We would especially like to thank the Aboriginal Controlled Community Health Services who contributed to the development of the evaluation design and methods through consultations with the evaluation team, participated in interviews for the evaluation, and commented on the report. We acknowledge the NSW Aboriginal Health and Medical Research Council which provided ethical approval for this evaluation project.

Thanks also to the staff of MHDAO, NSW Ministry of Health (Linda Carroll and Christine Flynn) who supported and guided this evaluation.

Lists of those who contributed to the evaluation are provided in Appendix 1.

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Abbreviations and acronyms

ACCHS	Aboriginal Community Controlled Health Services
AH&MRC	Aboriginal Health and Medical Research Council
AMHWF	Aboriginal Mental Health Workers Forum
AMS	Aboriginal Medical Service
AMIHS	Aboriginal Maternal and Infant Health Services
CAMHS	Child and Adolescent Mental Health Services
CSU	Charles Sturt University
FTEs	Full Time Employees
LHD	Local Health District
MH	Mental Health
MHDAO	Mental Health and Drug and Alcohol Office
NSW	New South Wales
Practical Guide	Walk Together, Learn Together, Work Together. A Practical Guide for the Training of Aboriginal Mental Health Professionals in New South Wales
The Forum	Aboriginal Mental Health Workers Forum, Terrigal, 2011
The Program	NSW Aboriginal Mental Health Worker Training Program

Executive summary

NSW Aboriginal Mental Health Worker Training Program

In July 2007, the NSW Government released the *NSW Aboriginal Mental Health and Well Being Policy 2006-2010* which provides a framework for addressing the mental health needs of Aboriginal people. It aims to guide NSW Health and mental health services in Local Health Districts (LHDs) across NSW in providing Aboriginal communities with culturally sensitive and appropriate mental health and social and emotional wellbeing services. Under this policy, funding was allocated to build a specialist workforce through the Aboriginal Mental Health Workforce Program. The NSW Aboriginal Mental Health Worker Training Program (the Program) is an important workforce development strategy that was built on the success of the (former) Far West Aboriginal Mental Health Worker Development Program. It aims to employ and train Aboriginal people as mental health professionals and is designed to develop a highly skilled and professional Aboriginal mental health workforce that provides mental health services to Aboriginal and non-Aboriginal people.

The program is overseen by the Aboriginal Mental Health Workforce Program Reference Group which reports to the Mental Health Program Council via the Aboriginal Mental Health and Well Being Reference Group on Program implementation and future directions. Around the time the Program started, funding was provided for Clinical Leader Aboriginal Mental Health positions in the previous Area Health Services (now LHDs) to support an emerging Aboriginal mental health workforce.

Policy context and commitment

The *NSW Aboriginal Mental Health and Well Being Policy 2006-2010* provides the mandate for the NSW Aboriginal Mental Health Worker Training Program. In 2010, the policy was extended to 2012.

The policy specifies the following actions:

Expand the successful elements of the Far West Aboriginal Workforce Development Project into the NSW Aboriginal Mental Health Workforce Program across a number of priority rural and metropolitan Area Mental Health Services in NSW.

- Employ local Aboriginal people as permanent employees to train as Mental Health Workers.
- Establish a coordinating and monitoring element through the MHDAO and the Centre for Rural and Remote Mental Health at Orange.
- Coordinate work and study in the Program with a system of peer support, supervision and mentoring.

- At completion, the trainees will become fully qualified Aboriginal Mental Health professionals, working as part of a mainstream Area Mental Health Service.¹
- A commitment to develop an Aboriginal mental health workforce is also circumscribed by other actions in the policy and these workforce development commitments are underpinned by the Policy.
- The NSW Aboriginal Mental Health Worker Training Program also contributes to the achievement of outcomes proposed under the NSW Health *Aboriginal Workforce Strategic Framework 2011-2015* and is consistent with national strategic direction—*National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-2009*.

Evaluation approach and methods

An evaluation framework and plan was developed for the evaluation project which included a program logic model, evaluation questions and data collection methods. An application for ethical approval was made to the NSW Aboriginal Health and Medical Research Council (AH&MRC) and consultations conducted with Aboriginal Community Controlled Health Services (ACCHSs) to inform the evaluation design. Approval to conduct the project was granted by the NSW AH&MRC.

Guided by discussions with NSW Health, we identified six key groups of stakeholders who could contribute to the evaluation, selected based on their involvement and knowledge of the program design and implementation. Both qualitative and quantitative data was collected to inform the evaluation, with our methods designed to provide comprehensive data from across NSW. These methods were

- Key stakeholder interviews
- LHD site visits and interviews
- Visits to ACCHSs
- LHD mental health service online survey.

The initial data collection involved interviews with key stakeholders in order to understand the policy context that influenced the program as well as the program's history, background and rationale. We also sought information from the Statewide Program Coordinator on the number of trainees who had entered and exited the Program since 2007.

In site visits to mental health services in all Local Health Districts and Justice Health we consulted 145 participants. Face-to-face interviews with current and graduated trainees, Aboriginal Clinical Leaders Mental Health, supervisors/preceptors/mentors, team leaders and Directors of Mental Health and of Aboriginal Health (see Appendix 1 for list of interviewees) captured the experiences of the key people involved in the program's delivery at a service level. Those not available during the site visit were interviewed by

¹ NSW Health (2007) *NSW Aboriginal Mental Health and Well Being Policy 2006-2010*. NSW Department of Health.

telephone a short time later. Summaries of the key information provided by trainees and graduates and by Aboriginal clinical leaders were developed and telephone consultations conducted with these groups to clarify the findings prior to writing the report.

We also visited three ACCHSs, who had agreed to participate in the evaluation, to gain their views and experiences of the Program with 14 ACCHS staff participating in group interviews.

To triangulate these qualitative findings, we developed an online survey for mental health services across NSW. Questions were based on findings from the site visit interviews and the Practical Guide, and explored themes around the delivery and outcomes of the training program. 150 mental health services were invited to participate and 52 completed the survey—an overall response rate of 35%. All but two LHDs submitted at least one survey response.

The major limitations of the evaluation data collection methods were the relatively low response rate of services to the survey and limited available program data on Program outcomes. While the qualitative data provided excellent in-depth information on individuals' experiences of the program, we did not seek to obtain a separate and precise picture of the history and success of the traineeship in each LHD.

Findings

Positive impact and challenges

Overall the Program is highly valued by LHD mental health services across NSW, and is increasing staff knowledge and understanding of Aboriginal mental health and cultural issues. It is also improving the capacity of LHDs to provide accessible and relevant services to local Aboriginal people. The Program is providing a unique opportunity for Aboriginal people to gain valuable skills and a tertiary qualification to work as mental health professionals, support their communities, and be role models for others. But the Program has faced many challenges over the last six years in achieving its planned outcomes, with mixed results in different areas. The strengths, weaknesses and challenges are summarised below.

Growth in the Program

There were originally 20 positions created, 19 trainee positions and the State-wide Coordinator position, but there has been such strong interest in the Program that LHD mental health services have created additional positions, usually by converting unfilled Aboriginal mental health worker positions to trainee positions. Since 2007, 96 trainees have commenced the program (a small number continued from the previous Far West Aboriginal Mental Health Workforce Development Project), 43 of these trainees have completed the Program, 25 left the program and 30 are currently trainees working in mental health services. There are 12 trainee positions currently vacant.

All areas widely advertised their trainee positions and most commonly trainees saw an advertisement in the Koori Mail, local paper or on the NSW Health intranet, while others found out through previous trainees, friends and relatives, or the University. The number and quality of applicants varied considerably and some positions were more difficult to fill, particularly in remote areas. Interview panels included Aboriginal health service staff and local Aboriginal community members.

Knowledge and understanding of Aboriginal mental health and other Aboriginal issues amongst mental health service staff

Aboriginal trainees have increased the knowledge of mental health service staff about Aboriginal mental health and many other Aboriginal issues through both formal and informal information exchange. LHD staff were generally eager to learn and trainees were proactive in informing them about Aboriginal culture, general and local Aboriginal history, and local Aboriginal community issues. Trainees mostly provided informal education to staff as opportunities arose but sometimes more confident trainees worked with community elders or other Aboriginal health system staff to provide more formal education in Aboriginal culture and other issues. Many service staff reported having learnt a lot about Aboriginal culture, the local Aboriginal community and how to work with Aboriginal clients.

Access to mental health services by Aboriginal people

All the available evidence indicates that having an Aboriginal trainee or graduate working in a mental health service is increasing the cultural awareness of other staff, and slowly making the service more accessible for Aboriginal people. Trainees and graduates from the local Aboriginal community were more likely to be known by the community and were working to allay people's fears about accessing the service. Trainees from outside the community were trying to increase community awareness of their presence in the service. Trainees needed to be careful not to create expectations in the community that they could not meet while they were still trainees. Some community members were believed to be more likely to access the mental health services if an Aboriginal person from the community worked there while others were reportedly more likely to want services provided by an Aboriginal person from outside their community.

To date, little hard data is available on increased use of services by Aboriginal clients but some LHDs have put processes in place to collect this data.

Preparation for trainees

While the majority of staff in hosting services supported the trainee joining the service, LHD mental health services were generally not well prepared for the trainee to start work, particularly where it was their first trainee. There were a number of areas,

however, where the Aboriginal clinical leader or other staff worked hard to prepare the service before the trainee arrived.

Box 1.1 Characteristics of good practice in preparing for a trainee

Mental health services that were well prepared for a trainee took most of the following actions:

- A member of staff took responsibility for ensuring the service was prepared.
- All staff received information and education about the Training Program and the role of the trainee, often in face-to-face meetings.
- Staff taking a specific role, such as team leader, supervisor or mentor, participated in meetings to clarify roles and prepare for the trainee, and perused the Practical Guide.
- An appropriate physical workspace was prepared for the trainee.
- Processes for planning and monitoring the workplace training experience were agreed.
- Information was obtained on the academic program.

Lack of preparation was related to work pressures within the service, lack of clarity about who was responsible for preparing the service, a narrow approach where only a few members of staff were adequately informed, lack of sufficient information provided to staff who were to be involved, and lack of understanding of the magnitude of the task of supporting a trainee for three years. Occasionally staff in services could not see the value of having a trainee. Nevertheless, most staff did their best to make the trainee feel welcome and most trainees felt welcomed by the service staff. It was suggested that preparation of the service could start much earlier and that staff need to be informed and involved before the decision is made to advertise for a trainee.

Workplace training and support

The majority of trainees had a good range of workplace training experiences during their traineeship that adequately prepared them for working as a qualified mental health worker. A community mental health service was the most common location for trainees but many rotated through different mental health services within the LHD to gain broader experiences. The most difficult time for both trainees and staff was in the first year of the traineeship as many staff were confused about how to occupy the trainees and the trainees were bored. Services that provided workplace experiences for trainees on rotation were often not as aware as hosting services about how to provide appropriate training experiences. Some trainees did not have adequate clinical experiences or sufficient opportunities for supervised client treatment and management in the final year of their traineeship. Almost all trainees gained some experience in working with Aboriginal clients, while those in areas with high numbers of Aboriginal people gained the most experience. A few trainees felt they were expected to resolve all the issues the service had in working with Aboriginal clients.

The quality of support provided to trainees varied across LHDs, and sometimes across hosting mental health services within LHDs. While supervisors, and preceptors or mentors were generally assigned to trainees, many had little or no preparation for the role. Good supervisors and mentors ensured a positive workplace training experience for trainees.

Box 1.1 Characteristics of good practice in supervising and mentoring trainees

Supervisors or mentors who provided good support to a trainee typically

- Knew the trainee's short and longer term objectives
- Had a reasonable understanding of the content of their academic program
- Planned workplace experiences that met their objectives
- Met regularly (weekly) with trainees to monitor their workplace training and progress
- Were aware of cultural issues that might impact on them
- Ensured the trainee had clinical supervision for clinical work
- Were aware of avoiding placing them in situations for which they were not prepared
- Advocated on behalf of the trainees within the service
- Checked on their progress with academic work and arranged additional support where required
- Established good relationships with the trainee and generally checked in regularly on their overall welfare and well-being.

Some staff assigned to a supporting role were not able to make sufficient time and resources available to support the trainees or were not able to organise enough meaningful workplace training experiences. In a few of the cases where appropriate training and support for trainees was not provided, the relationship between the trainee and service was seriously damaged and some trainees eventually needed to go on stress leave or workers' compensation. These situations caused great hardship for the trainee and severe angst for the service.

Aboriginal clinical leadership

The role of Aboriginal clinical leader is critical for the successful support of trainees. An actively involved Aboriginal clinical leader is a dedicated resource that significantly enhances a service's ability to successfully host a trainee, and improves a trainee's training experience. Since the change from Area Health Services to LHDs, most clinical leaders have focussed on providing services to one LHD (due to feasibility issues or HR direction) which means that several LHDs hosting trainees now have little or no support from an Aboriginal clinical leader. In a few cases where an Aboriginal clinical leader was not available another senior staff member successfully took on the role but they were not able to provide the cultural support that was provided by the Aboriginal clinical leader and highly valued by trainees.

The Practical Guide

The Practical Guide, which was developed to guide the traineeship experience for both trainees and the staff supporting them, is seriously underutilised, especially by mental health service staff. Most of those who used the Guide extensively thought it was very useful, but a number of those using the Guide said it was not user friendly and/or insufficient for their needs and needed to be reviewed. An appropriate manual or guide for the Program is essential and adequate training to educate staff and trainees in the use of the guide is also essential. More development and training in use of an online resource should be considered.

Involvement with Aboriginal Community Controlled Health Services

In most cases the trainees' workplace training lacked the planned interaction with ACCHSs. Where trainees did spend time at an ACCHS, all parties valued the experiences. ACCHSs themselves are very keen to be more involved with the Program and believe workplace experience in an ACCHS will help trainees understand more about working with Aboriginal people who have mental health problems. Poor relationships between LHDs and ACCHSs often prevent trainees from gaining experience working in an ACCHS. LHDs could explore this option more actively.

LHD leadership and commitment to the program

In a number of LHDs there was good senior management support for the Program but, in many others, senior managers knew little about the Program. Senior executives and clinical directors of mental health services need to be knowledgeable and actively engaged with the Program to ensure sound management and accountability processes are in place in mental health services supporting trainees. Most services and their staff did not initially understand the level of commitment required to host a trainee for three years. This understanding is imperative in order for services to prepare and provide an appropriate workplace training experience for a trainee. Nevertheless, most services and supporting staff learnt how to provide a valuable training experience for their trainee. The roles of staff supporting the trainees need to be better understood and these staff need to be supported to adequately fulfil those roles. More consistent implementation of planning and performance review processes would provide better information on services' performance in supporting trainees, trainees' actual workplace experiences and their development of required knowledge and skills.

Improved knowledge of Aboriginal culture

Many trainees found that the level of Aboriginal cultural awareness in mental health services was low but believed a higher level of knowledge and awareness was important for both themselves and Aboriginal clients. Some services provided high quality training in Aboriginal cultural knowledge and awareness that was valued by staff and trainees. Many trainees believed that current cultural awareness training was tokenistic—most trainees tried to improve awareness in their workplace through either formal or informal approaches. A number of interviewees referred to the NSW Health program 'Respecting the Difference' which is gradually being introduced across the state by NSW Health—interviewees generally had limited knowledge about this program.

Interviewees and survey respondents generally reported that services needed more support from Program staff and the NSW Ministry of Health. Service staff, and particularly Aboriginal clinical leaders, wanted more information from the Ministry, more contact with the State-wide Program Coordinator and more opportunity for providing feedback.

The academic program

Most trainees reported that undertaking the degree at Charles Sturt University (CSU) was a highlight of their traineeship. They valued the opportunity to gain a tertiary education and qualification and grew in confidence as a result of completing the academic program. They believed they had become role models for family and community members who also hoped to undertake tertiary education. Most trainees believed that the CSU academic program had been sufficient for their role as an Aboriginal mental health worker but would like a few additional content areas added. A few trainees thought the Program was not sufficient.

Many people involved with the Program, including the trainees themselves, were concerned that the academic standards of the Djirruwang Program were lower than those of other university courses—this has impacted on the perception of the qualification that trainees obtain. Recent changes to the Program since the new Director was appointed indicate that academic standards, and the content and quality of the academic program have improved considerably and should be closer to meeting the needs of trainees and their LHD employers—this will need to be assessed and monitored. The clinical component of the academic program is also undergoing changes with increased commitment by the University to ensuring students are adequately supported to achieve clinical placement objectives. This should reduce the burden on mental health staff in organising appropriate clinical placements. The university has recently completed their final response to the 2010 external review of the Djirruwang Program but this information was not available to the evaluators.

Some trainees, particularly those with limited previous educational experience, face difficulties undertaking the academic program and need more support—the university has instituted a process for picking up these students earlier and is providing ongoing, structured support. Many trainees would benefit from having a tutor and these are available through a Commonwealth funded program administered by the university's Indigenous student support services. In practice there are barriers that need to be overcome and only some trainees were able to overcome these and secure a tutor. Communication between the university and the mental health services is variable and currently unsatisfactory for both—processes need to be clearer and more consistent.

There is no clear process within NSW Health for reviewing whether the current academic component provided by CSU is meeting the needs of the Program. This evaluation found strengths and weaknesses of the current arrangements. On the positive side, the current academic program provides Aboriginal specific mental health tertiary education that is accessible for many Aboriginal people and provides a valued and recognised Aboriginal mental health worker qualification. On the other hand, some trainees and services would prefer that an academic program leading to one of the four professional qualifications be undertaken (nursing, social work, psychology, occupational therapy) as these qualifications were perceived to be well recognised and to provide better opportunities for further employment. There are, however, considerable benefits in all trainees undertaking the same academic program. As some

LHDs are independently considering alternative academic programs, policy direction is needed to ensure that the academic component is meeting the needs of trainees and the Program, and that there are clear processes for monitoring and reviewing this.

Factors promoting success

Sound workplace training and good academic progress ensured successful completion and transition to qualified mental health worker.

Trainees who made a relatively smooth transition to the role of qualified mental health worker had developed confidence as a result of well supported workplace experiences, particularly clinical experiences, and gradual increases in responsibility and contribution to client treatment and case management. Successfully completing the academic program and quality workplace experiences ensure that trainees graduate and commence work as qualified mental health workers.

Twenty five trainees left the Program before graduating. While limited information was available, the main reasons appeared to be failure to complete the academic program, dissatisfaction with the workplace training experience or personal circumstances.

Positions and employment conditions after graduation

Availability of positions, and appropriate titles, pay rates and conditions for Program graduates needs to be clarified.

Hosting LHDs would like to retain their trainee as a qualified Aboriginal mental health worker in their mental health service when they complete the traineeship. In many cases this is happening and as at March 2013 there are approximately 21 Program graduates working in LHD mental health services, mostly as Aboriginal mental health workers. Some health services believe that training Aboriginal mental health workers is a valuable exercise, even if the trainees leave their service after graduation, as they are contributing to building an Aboriginal health workforce. In some LHDs, service staff reported they were not sure whether they could offer the trainee a permanent position after graduation, due to lack of a vacant position and HR requirements, even though this is a condition of the traineeship. Some LHDs are reportedly changing the contracts of trainees so that they are not guaranteed a position on graduation, contrary to the conditions of the Program as stipulated in NSW Ministry of Health Project Summary document.

As Program graduates with clinical qualifications transition into permanent positions as Aboriginal mental health workers the previously understood role of an Aboriginal mental health worker is changing, and some interviewees had concerns about the status of the role and title. There is also confusion amongst trainees, graduates and service staff about whether Program graduates should have the title of Aboriginal mental health worker and what this means in practice, particularly as trainees have been trained to provide services to both Aboriginal and non-Aboriginal clients, and because some Program graduates are actually occupying mainstream positions. Aboriginal mental

health workers who are undertaking or have completed the Bachelor of Health Science (Mental Health) at CSU were recognised in 2012 as allied health professionals by Indigenous Allied Health Australia. Some interviewees however, still had concerns about the title of Aboriginal mental health worker, the status of the role, and the associated remuneration.

Some interviewees felt that to achieve the goals of the Aboriginal Workforce Program a reasonable number of Program graduates need to be retained in LHD mental health services and a career trajectory for graduates needs to be clarified, especially in the light of the reduced numbers of Aboriginal Mental Health Worker positions in LHDs (having been converted to trainee positions), and the limited number of other Aboriginal specific positions (e.g. clinical leaders).

Graduating trainees are usually paid under the Aboriginal Health Education Officers Award but this is generally felt to be an inappropriately low level of recognition, given their qualifications. A few LHDs have moved graduates to the Health Professionals Award, thereby aligning them with other similar positions within the mental health workforce and enhancing their career opportunities. This award also has a higher rate of pay for new graduates, so this change has created inequalities across the state for new graduates of the Program.

Scope and resourcing of the Program

The scope of the Program is becoming unclear with a number of trainee positions not directly funded under the original funding allocation and some positions now embraced by the Program not located in LHD mental health services. The number of trainees participating in the Program has increased—from the 19 originally funded positions there are now 30 current trainees and even more positions available. Interviewees believed that the increased scope of the Program meant that the Statewide Coordinator position could not adequately support all the services hosting trainees, particularly as that position also had other responsibilities under the Statewide Aboriginal Mental Health Workforce Program. As a result some areas are very satisfied with the support they have received from the Statewide Coordinator while others are quite dissatisfied.

The Statewide Coordinator used an audit tool to gather data on progress and satisfaction with the Program among mental health services hosting trainees but this tool was only completed by a small number of service staff and trainees. There are also limited systems in place to monitor and track trainee progress, academic completion or employment after graduation and it is currently difficult to obtain accurate data on most aspects of Program implementation and outcomes due to lack of systematic Program administrative data.

Program governance

Interviewees in more senior positions often reported that Program governance processes were not working as well as they should be. The number of members of the Program Reference Group attending meetings has fallen and was consistently low in

2012 with generally less than half of the members attending. Key stakeholders reported that issues and concerns about the Program that were raised at the Reference Group and taken to the NSW Aboriginal Mental Health and Well Being Reference Group were not adequately considered or acted on by that group. Trainees who faced unsurmountable problems in their workplace felt there was no clear mechanism for having their concerns heard or addressed apart from approaching the Statewide Coordinator.

A Project Summary prepared in 2008 by the NSW Ministry of Health is the only statewide policy document guiding the Program and appears to be rarely referred to, or even known about. The other policy documents providing direction are the Position Allocation Summaries for the trainee positions and the Aboriginal mental health worker positions. These documents are prepared only once when new positions are created. While the Practical Guide has status as a guide to program implementation, its role in accountability and compliance with Program direction is not clear, particularly as it is not being used by many mental health services hosting trainees. There is a lack of clear direction and lack of accountability processes for LHDs hosting trainees under the Program—current reporting arrangements appear to be inadequate. The Program needs a clear set of policy directives that are well communicated to all LHD Chief Executives, Directors of Mental Health, other relevant senior managers in LHDs, and mental health services hosting trainees and include accountability and compliance mechanisms.

There is clearly a Ministry commitment to reviewing Program outcomes through undertaking this evaluation but there are limited resources and processes within the Ministry for ongoing management and monitoring of the Program. This also needs to be addressed. More commitment and resourcing for ongoing monitoring and evaluation need to be built into the Program.

Conclusions

The Aboriginal Mental Health Worker Training Program is highly valued by LHD mental health services across NSW. Through training Aboriginal mental health workers, mental health services are gaining knowledge and understanding about Aboriginal culture and issues and about their local Aboriginal community. Therefore, the Program is improving the capacity of mental health services to provide accessible and relevant services to local Aboriginal people. The Program is providing a unique opportunity for Aboriginal people to gain valuable skills and a tertiary qualification that enables them to work as mental health professionals and be role models for their communities.

This evaluation has, however, raised a number of issues that are impacting on achieving the planned outcomes of the Program and that need to be addressed. These fall under one of the following three questions.

1. How to strengthen the governance, accountability and management of the Program. There is a need for: more clarity around the scope of the Program; a review of the Program resources when scope is clarified; better systems for review and monitoring of Program processes and outcomes; renewed policy directives to guide

Program management and implementation; improved compliance and accountability; and more effective governance systems.

2. How to strengthen workplace based training. It seems that not all services have the capacity or the staff with required skills to provide suitable workplace training for trainees. Systems need to be established to ensure services interested in employing a trainee are knowledgeable about the Program, have the necessary capacity and resources and are provided with adequate training, guidance and support throughout the traineeship. The Program needs to achieve a higher level of consistency in trainee experience across the State.

3. What is the best option for a tertiary degree for the trainees? The Program arrangements, as stipulated in the MHDAO Project Summary, and outlined in the Practical Guide, allow for students to be enrolled in a relevant university course leading to a tertiary qualification in a recognised field in mental health. Currently all trainees undertake the Bachelor of Health Science (Mental Health) Degree (Djirruwang Program) at Charles Sturt University—a decision made by the Program Reference Group in late 2006/early 2007. There are no clear mechanisms, however, for making decisions about whether students should be undertaking the same degree (as is currently the situation), or different degrees (as allowed for under the current policy), and which degrees should be undertaken. There is pressure from some areas to enrol students in degrees other than the current CSU Djirruwang program. Therefore a clear governance process for reviewing the current arrangements and considering alternatives and implications is required.

Any changes to the Program need to be seen in the light of the overall policy direction to build an Aboriginal mental health workforce and address the needs of Aboriginal communities and individuals for quality, accessible mental health services. This Program is clearly yet to achieve its full potential. The findings of this evaluation provide an opportunity to build on the considerable achievements to date, and ensure that the Program achieves its desired outcomes into the future.

Recommendations

Based on the findings of this evaluation we recommend a combination of high level policy action and practical changes in implementation to address current issues and strengthen the Program.

Working party to review and strengthen the Program

1. A working party should be set up by the NSW Ministry of Health comprising people experienced in the Program to review a number of areas of the Program (see 2. below) and take action to strengthen Program implementation, direction, governance and accountability. This group should be chaired by a senior manager of the Mental Health and Drug and Alcohol Office (MHDAO) and include representatives of
 - Aboriginal Clinical Leader Mental Health Group
 - Senior staff in LHD mental health services that have hosted trainees
 - Program graduates
 - Senior officers from MHDAO (including the Chair)
 - Aboriginal Health and Medical Research Council (AHMRC) representing Aboriginal Community Controlled Health Services, possibly via the AHMRC Statewide Coordinator for Mental Health position
 - NSW Ministry of Health, Aboriginal Workforce Development section
 - the Statewide Program Coordinator
 - Others as deemed necessary.

Review program direction, governance and accountability

2. The working party should undertake the following tasks (some or all could be externally commissioned but overseen by the working party):
 - a) Review governance arrangements for the Program including: LHD reporting requirements; functioning of the Program Reference Group; reporting pathways; and the management of issues escalated by the Program Reference group to higher levels of governance.
 - b) Review the Position Allocation Summaries for the trainee positions and recommend changes as appropriate. This should encompass specifications around permanency; processes for reviewing the content of the summaries; which positions the summaries apply to.
 - c) Review the variety of processes used by LHDs for providing permanent positions for graduating trainees and any LHD human resource requirements or restrictions impacting on this; make recommendations and provide guidance for LHDs on a process which is consistent with the principles of the traineeship Program, and meets the needs of Program graduates, mental health services and LHD HR administration procedures.
 - d) Review the award classifications being used by LHDs when employing Program graduates and determine whether the Aboriginal Health Education Officer (graduate) award or the Health Professionals award or another award, is the most appropriate. Provide guidance to LHDs on the most appropriate award.
 - e) Review the role of an Aboriginal Mental Health Worker, including: perspectives on the position amongst Program trainees and graduates and mental health

service staff; the availability of the positions across the State; the roles and responsibilities of the position and implications for pay and conditions; and make recommendations for the future.

- f) Review the changing scope of the Program and clarify the Program's boundaries, including the number of trainee positions covered by the Program.
- g) Review Aboriginal Clinical Leader Mental Health positions and, if necessary, make recommendations for additional resources to improve distribution throughout the state, in order that they can properly fulfil their support role in this Program.
- h) Review position descriptions for Aboriginal Clinical Leaders Mental Health to ensure they accurately reflect their role in supporting the Program.
- i) Review and investigate strengthening both management and peer support for Aboriginal Clinical Leader Mental Health positions.
- j) Review the role of the Statewide Program Coordinator in the light of the recommendations of this report and consider whether the position needs to have a more strategic, rather than operational, role and responsibilities.
- k) Review the resources applied to the Program in the light of the changed scope and recommendations in this report.
- l) Review arrangements for the academic component of the Program, including: monitoring implementation of planned changes to the Djirruwang Program and the CSU response to the 2010 External Review
- m) Consider the advantages and disadvantages of all trainees undertaking the same or alternative academic programs; and specify mechanisms for changing the arrangements for the academic component of the Program in the future, and embed these in policy.

New policy directive

3. The current statewide Project Summary document and any documents previously provided to AHS should be reviewed and improved policy and documentation developed to provide more direction and guidance to LHDs. A stronger mechanism should be developed to ensure the Program is implemented appropriately, complies with requirements outlined in the Practical Guide, and to document accountability. The revised policy document should be publicised to ensure broad awareness among stakeholders.

Strengthen program implementation

4. Implementation of the Program needs to be strengthened, with the following priorities to be addressed by the Statewide Coordinator and program support staff:
 - a) Provide applicants for the trainee position with more detailed information about the Program including key points from the Practical Guide.
 - b) Conduct information sessions for mental health services before recruiting a trainee, even if they have previously had a trainee. As many staff as possible should attend these sessions and contribute to decisions about whether to host a trainee.
 - c) Develop an audit form for services to rate their capacity and resources to host a trainee.

- d) Provide more guidance to mental health services around educating staff and preparing the service to host a trainee—this should operationalise the Program in accordance with the Practical Guide and could include a small number of easy-to-use templates, forms, presentations or other materials, which have been specifically designed for use by mental health services hosting trainees.
- e) All staff in services hosting a trainee should participate in an information session conducted by the Aboriginal clinical leader or other senior manager and supported by Program staff. Templates and guidance should be provided by Program staff to mental health services so there is consistency of information provided to service staff across services. The information sessions should cover
 - Likely workload
 - Roles and responsibilities of involved staff
 - Trainees’ roles and responsibilities
 - The need to recruit trainee into the workplace three months before the first academic residential
 - How to use online or hard copy program materials
 - Issues that might arise during the traineeship and ways of addressing these
 - How to prepare for the arrival of a trainee, including organising Aboriginal cultural awareness training for all staff
 - How to prepare trainee workplans and monitor performance
 - Guidance for supervising and mentoring trainees.
- f) Similarly, all relevant staff of services providing a workplace experience for a trainee as part of a workplace rotation schedule should receive the same information session as hosting services. These should be conducted by the Aboriginal clinical leader or other senior manager (as outlined above).
- g) Make available more structured and planned support for all supervisors of trainees, middle managers and other supporting mental health staff during the traineeship. This could include an online forum, biannual teleconference meetings or other suitable arrangements.
- h) Hold a yearly information and education session on the Program for Directors of Mental Health services. This session should clarify the leadership role of the Director of Mental Health in ensuring their service has the capacity to host a trainee, actively monitor progress with the traineeship over the three years, undertake the proposed mandatory surveys, and report against key performance indicators.
- i) The Statewide Program Coordinator and the Statewide Coordinator for Mental Health, auspiced by the Aboriginal Health and Medical Research Council, should engage with Aboriginal Community Controlled Health Services (ACCHS) and mental health services to improve opportunities for trainees to gain experience working in ACCHSs during their traineeship.
- j) Promote the Practical Guide and develop user-friendly resources to accompany it that support accessibility and consistent use of the Guide by all services hosting trainees, and that better meet the needs of these services
- k) Ensure easy access to an online version of the Practical Guide and promote its use

Communication between mental health services and the University

5. Establish an agreed mechanism for communication between mental health services and the University on trainees' academic progress. The University prefers to have a single point of contact and it is recommended that this be the proposed new Program staff member, if funded, (see recommendation 6 a). This role will include liaison with the mental health services. Processes for mental health services obtaining trainee's academic transcripts need to be reviewed and expedited.

Program management

6. Review Program management resource requirements to ensure they meet the expanded needs of the Program:
 - a) Consider how to apply additional human resources to the Program to address the challenges identified and implement improvements to achieve its objectives. This could include reconfiguring or maximising existing human resources, and/or funding an additional Program staff position. This position should report to the Statewide Program Coordinator and undertake development and coordination tasks. The position should develop resources and processes for information sessions for mental health services, develop tools for ongoing monitoring, liaise between mental health services and the University, administer surveys and analyse data (see c) and d) below), and resolve day to day problems encountered by trainees and services.
 - b) Build an effective and robust system for trainee data management, using database software such as Microsoft Access, to monitor trainee participation and outcomes.
 - c) Establish an ongoing program monitoring system that includes
 - key performance indicators for LHDs hosting trainees (based on the revised Program documentation or policy and the Practical Guide)
 - annual reporting by LHD mental health services currently hosting trainees using a prescribed tool (possibly through an online survey)
 - collated information from a survey and/or interview of Program graduates and relevant staff of their hosting service on completion of traineeships
 - collated, de-identified information from trainees who leave the program before completion of the traineeship and their reasons for leaving and/or feedback for the Program.