# Aboriginal Family Health Strategy Evaluation

December 2015

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All research conducted by CIRCA for this project was in compliance with ISO20252

# Acknowledgements

The Cultural and Indigenous Research Centre Australia (CIRCA) wishes to acknowledge Aboriginal and Torres Strait Islander people as the traditional owners of Australia and custodians of the oldest continuous culture in the world, and pay respects to Elders past and present.

We would like to thank all those who generously contributed to the evaluation. In particular we would like to thank the Aboriginal Family Health Workers, Aboriginal Family Health Coordinators, ACCHS chief executives, managers, team leaders and key stakeholders.

We would also like to thank the Ministry of Health, in particular staff from the Centre for Aboriginal Health and the Centre for Epidemiology and Evidence and NSW Kids and Families, for their valuable partnership in this evaluation.

# Executive summary

## Background

Family violence has an enormous impact on the health and social and emotional wellbeing of Aboriginal communities in NSW. Family violence in Aboriginal communities is complex, and includes physical, emotional, sexual, sociological, economic and spiritual forms of violence. The impact of family violence in communities must be seen in the context of cultural, social, political and economic disadvantage. This complexity is exacerbated as individual and collective inter-generational trauma experiences have been contributed to by power dynamics, racism and discrimination.

As part of its commitment to reducing the incidence and impact of family violence, by working in partnership with Aboriginal people and their communities, NSW Health developed the *Aboriginal Family Health Strategy 2011-2016: Responding to Family Violence in Aboriginal Communities* (AFHS). The aims of the AFHS are to:

- Reduce the incidence and impact of family violence in Aboriginal communities
- Build the capacity and strength of individuals and communities to prevent, respond to and recover from family violence
- Nurture the spirit, resilience and cultural identity that builds Aboriginal families.

The AFHS provides the NSW Health response to family violence in Aboriginal communities through 24 Aboriginal Family Health Worker (AFHW) positions in Aboriginal Community Controlled Health Services (ACCHSs), non-government organisations (NGOs) and Local Health Districts (LHDs), and four Aboriginal Family Health Coordinators (AFH Coordinators) in four LHDs.

AFHWs provide crisis support, advocacy and referral to other services as well as broader community development and education activities, with a focus on prevention and early intervention. The aim of the AFH Coordinator positions is to facilitate improved system planning and coordination of service delivery, and to provide linkage between the NSW Health system, NGOs and whole of government initiatives addressing family violence in Aboriginal communities.

## Evaluation approach

The NSW Ministry of Health commissioned the Cultural and Indigenous Research Centre Australia (CIRCA) to conduct an evaluation of the AFHS.  A mixed methods process evaluation was undertaken including interviews with AFHWs, AFH Coordinators and key stakeholders at the state and local level, analysis of AFHW data collection forms and AFH Coordinator reports, and a document review.

## Key findings

Across the evaluation, feedback on the AFHS was consistently positive in relation to the overall effectiveness and appropriateness of the AFHS. The AFHS was felt to be culturally appropriate and relevant, due to its focus on family and local community needs, its acknowledgement of inter-generational trauma and the fact that it is delivered by Aboriginal workers.

The evaluation evidence presented in this report highlights the key strengths and challenges across the areas of implementation and effective service delivery, strategic leadership, culturally competent

workforce and strong community capacity. These key achievements and challenges are summarised below.

## Implementation and effective service delivery

### Key achievements & strengths

- The implementation approach varied across the different locations in response to local community needs. The evaluation indicates that all the AFHWs implemented approaches covering the areas of prevention and early intervention, crisis intervention and support, and community development and education.
- Most of the organisations take a holistic approach to service provision. AFHWs and their managers reported that in addition to supporting clients in relation to family violence, sexual assault and child protection issues, AFHWs often provide support to clients for other complex issues such as mental health and drug and alcohol issues.
- In implementing the AFHS, AFHWs and AFH Coordinators have conducted a wide range of activities with considerable reach. High numbers of self-referrals indicate a high level of engagement with the community by AFHWs.
- The statewide network meetings and training courses have been key avenues for connecting between AFHWs and were highly valued.
- Some AFHWs have built relationships and are in contact to share ideas and discuss experiences, and there was evidence of AFHWs sharing resources and templates and collaborating to coordinate events in their regions.
- Overall, AFHWs and AFH Coordinators work in a collaborative manner with other local services, and a broad range of partnerships, networks and stakeholder relationships have been developed.
- AFHWs are members of interagency forums and domestic violence collectives or working groups, with some establishing these groups themselves.

### Key challenges

- The funding allocation for the AFHW positions was identified as limiting the reach of services and the initiatives that can be implemented by AFHWs, as well as contributing to challenges with recruiting suitable candidates for the AFHW position. Participants also felt there was a need for an increased workforce to implement the AFHS.
- A lack of emergency crisis accommodation and alcohol and other drug rehabilitation services were cited as barriers to successfully delivering services that meet client needs.
- A shortage of services and programs to support men and a shortage of male workers across services were identified as a significant challenge to responding to family violence in Aboriginal communities.
- Participants felt that a lack of promotion of the AFHS has led to low levels of awareness of the AFHS in mainstream violence prevention initiatives and frameworks.
- For some AFHWs, connection has been limited to the statewide network meetings, with several noting that although usually conducted every six months, prior to November 2014, a network meeting had not been conducted in over a year, making it difficult for newly appointed AFHWs to make connections.
- Although AFHWs and AFH Coordinators reported good working relationships with other services and stakeholders, a number of challenges in developing relationships and building partnership were identified. These included high staff turnover, people being protective of their clients, a lack of continuity in funding for the sector more broadly, and competition for limited funding.
- As with many initiatives that address complex needs among families and communities, it has been difficult to capture through program monitoring data the extent of the work being undertaken by AFHWs and AFH Coordinators, particularly the more qualitative components (e.g. community engagement, building partnerships with other services, and stories of change among families and communities).

## Strategic leadership

### Key achievements & strengths

- The AFH Coordinator positions are highly valued and are seen to contribute significantly to the implementation of the AFHS.
- Participants felt that the role is pivotal in supporting AFHWs at a local level, supporting the Aboriginal workforce more broadly across the LHD, improving the cultural competence and appropriateness of service provision to Aboriginal families, creating networks in the family violence service sector, and advocating for and being involved in decision making about violence prevention strategies to improve service delivery for Aboriginal families.
- The feedback indicates that the AFH Coordinators have contributed significantly to building the capacity of the sector by coordinating training and supervision across the region. AFH Coordinators are an avenue for advice and support for their colleagues working with Aboriginal families.
- It was reported that strategic partnerships have been developed at the local and regional level with a wide range of government agencies including NSW Family and Community Services, NSW Police, the NSW Ombudsman, Aboriginal Affairs, the Department of Education and Communities and the NSW Health Education Centre Against Violence. Partnerships have also been built with ACCHSs to facilitate better access to NSW Health services and resources and with local services in order to enhance cultural capacity of the health workforce.

### Key challenges

- Participants felt that the lack of promotion and visibility of the AFHS has impacted the development of partnerships at a strategic level.
- Balancing the range of activities that make up the AFH Coordinator role was identified as a challenge, especially as there is one AFH Coordinator working across a LHD. Feedback also indicated that uncertainty around the role has made forward planning challenging, and some felt this limited what could be achieved in a pilot position.
- Despite being well supported by their direct managers, the evaluation indicates that AFH Coordinators receive differing levels of support from senior management within their LHDs. This is reflected in the executive committees and meetings they are included in and the commitment of these groups to engage in the issues raised by the AFH Coordinator.

## Culturally competent workforce

### Key achievements & strengths

- A key finding from the evaluation was that the AFHS has contributed to the development of a skilled, supported and culturally competent workforce. The AFHWs and AFH Coordinators felt that their knowledge, skills and capacity had been enhanced through the AFHS, as had the capacity of others working in the sector.
- Through the AFHS, AFHWs and AFH Coordinators have accessed a range of training opportunities relevant to preventing and responding to family violence in Aboriginal communities, and these were seen as critical in building knowledge and skills.
- The evaluation indicates that the reach of training and skills development extended beyond the staff employed under the AFHS. Specifically, AFHWs and AFH Coordinators spoke about their role in increasing the capacity of other staff within their organisations to respond to family violence, as well as building the cultural competence of non-Aboriginal staff.
- The experience, training and skills gained through the AFHS were seen to contribute to enhanced career opportunities and pathways, and assist in achieving career aspirations.
- AFHWs and AFH Coordinators generally indicated that they were well supported in their roles. A range of supports were discussed, and the combination of these was a key contributor to overall feelings of being well supported.

**Key challenges**

- It was recognised that capacity building across the workforce in relation to cultural capacity is an area that requires further work and development, and significant time investment.

## Strong community capacity

**Key achievements & strengths**

- Consultation to identify community needs was seen as an important component when implementing the AFHS.
- In most cases identifying community needs and community consultation was conducted through informal processes, which was felt to be appropriate given the sensitive nature of the topic and the need to be responsive.
- AFHWs and AFH Coordinators feel the AFHS initiatives are generally meeting local needs, particularly those identified through the abovementioned consultation processes. This is further evidenced through the locally driven implementation of the AFHS itself, the range of diverse initiatives implemented across the communities, and the sense of local ownership promoted through the employment of local community members into AFHW roles.
- The AFHS was felt to increase the knowledge, skills and capacity of Aboriginal communities to prevent and respond to family violence. This was a strong evaluation theme, with AFHWs and AFH Coordinators pointing to a range of evidence indicating that this had been the case. Examples given included communities being more willing to speak about family violence, increased attendance at family violence education programs, and greater engagement by men on the issue.
- Community education and engagement were seen to be key facilitators in improving community capacity.

**Key challenges**

- The level of community engagement varied across locations, with some locations mainly focussed on involving clients while others involved the community more broadly.
- While feedback indicated that community consultation had influenced service planning, some participants suggested that there could be broader community participation.
- The extent to which this evaluation can assess whether AFHS initiatives reflect local needs and have led to community ownership is limited given community members were not included in the evaluation plan.
- Given the sensitivity and complexity of the issue, community change will be slow and require long-term effort and input, and attributing community change to the AFHS is difficult, as the changes identified are a result of collaborative and community efforts, of which the AFHS is a part.

## Conclusions and recommendations

Overall, the evaluation found that the AFHS, specifically the two key components of the AFHW and AFH Coordinator roles, were considered by stakeholders to have been effective and appropriate. The activities and outputs delivered by the AFHS have been locally driven and varied across communities and LHDs. AFHWs, AFH Coordinators, managers and ACCHS chief executives felt that the AFHS is a valid and purposeful way of delivering services and the evaluation indicates that the AFHS has reached the intended client groups.

A key limitation for the current evaluation is that qualitative feedback was limited to those involved in implementing the AFHS. Future monitoring and evaluation could capture feedback from community members and other stakeholders in order to better understand the reach and impact of the AFHS.

The following recommendations are offered for consideration in the implementation of the AFHS into the future across the areas of effective service delivery, strategic leadership, culturally competent workforce, strong community capacity and monitoring and evaluation.

**Implementation & effective service delivery**

1. Continue to strengthen the AFHS including AFH Coordinator positions
2. Consider the following challenges in future planning:
   - Program funding for AFHS activities implemented by AFHWs and AFH Coordinators
   - Recruitment and retention of staff, particularly in remote and challenging locations
3. Ensure network meetings are held regularly and improve induction processes to better support new workers and facilitate connections between AFHS positions
4. Facilitate connections between AFHS positions and other relevant partners and stakeholders, including ACCHSs, relevant LHD staff and government agencies
5. Maintain flexibility in AFHS approach so that AFHW and AFH Coordinator roles can continue to be responsive to local needs and contexts
6. Facilitate greater sharing of resources and tools (e.g. a central website or portal and a private social networking page for AFHWs and AFH Coordinators)
7. Refine program monitoring in consultation with AFHWs and AFH Coordinators. This should include:
   - Updating data collection systems to record program activity and also capture qualitative and narrative data more effectively
   - Developing a template or platform for AFHWs and AFH Coordinators to support ongoing monitoring data collection, with the capacity for this to output periodic reports required by NSW Health and enable aggregation across the AFHS
   - Reinstating and refining ongoing monitoring systems, including providing feedback on submitted reports

**Strategic leadership**

8. Consider strategies to better integrate the AFH Coordinator role into existing relevant LHD structures e.g. inclusion on executive and management committees
9. Undertake greater promotion of the AFHS to facilitate the development of strategic partnerships and visibility in mainstream violence prevention initiatives and frameworks

**Culturally competent workforce**

10. Continue to support AFHWs to undertake the Certificate IV in Aboriginal Family Health (Family Violence, Sexual Assault & Child Protection) and further relevant education, in particular the Advanced Diploma in Aboriginal Specialist Trauma Counselling
11. Identify additional opportunities to support skills and capacity development, such as traineeships for AFHWs

**Strong community capacity**

12. Continue resourcing the Education Centre Against Violence to deliver community education around family violence and family health
13. Investigate strategies to support AFHWs and AFH Coordinators to extend community engagement and participation
14. In planning future evaluations of the AFHS, investigate ways to obtain feedback from community members in order to further assess the effectiveness of the AFHS in building community knowledge, capacity and ownership, and responding to local needs

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# Acronyms

| | |
|---|---|
| ACCHS | Aboriginal Community Controlled Health Services |
| AFHS | Aboriginal Family Health Strategy |
| AFHWs | Aboriginal Family Health Workers |
| AVO | Apprehended Violence Orders |
| CHIME | Community Health Information Management Enterprise |
| DV | Domestic Violence |
| ECAV | NSW Health Education Centre Against Violence |
| FaCS | Department of Family and Community Services |
| GPs | General Practitioners |
| JIRT | Joint Investigation Response Teams |
| KTS | Keep Them Safe |
| LHD | Local Health District |
| NGOs | Non Government Organisations |
| WDVCAS | Women's Domestic Violence Court Advocacy Service |

# 1. Background

Family violence in Aboriginal communities is complex, and includes physical, emotional, sexual, sociological, economic and spiritual forms of violence. Family violence experienced by Aboriginal communities is not limited to intimate partner violence, but is inclusive of extended family and kinship structures. The vulnerability and impact of family violence in communities must be seen in the context of cultural, social, political and economic disadvantage. This complexity is exacerbated as individual and collective inter-generational trauma experiences have been contributed to by power dynamics, racism and discrimination.

Family violence has an enormous impact on the health, social and emotional wellbeing of Aboriginal and Torres Strait Islander communities in NSW. This is reflected in statistics identifying:

- Aboriginal women were 35 times more likely to be hospitalised due to family violence related assaults than non-Aboriginal women. (ANROWS, 2014)
- Aboriginal men are four times more likely to be victims of domestic violence than non-Aboriginal men (NSW Department of Premier and Cabinet, 2009)
- Sexual assault of Aboriginal children is highly associated with incidences of family violence (Aboriginal Child Sexual Assault Taskforce, 2006)
- The Aboriginal child death rate from injury is 3.6 times higher than for non-Aboriginal children (Australian Institute of Health and Welfare, 2014).

## 1.1 The Aboriginal Family Health Strategy

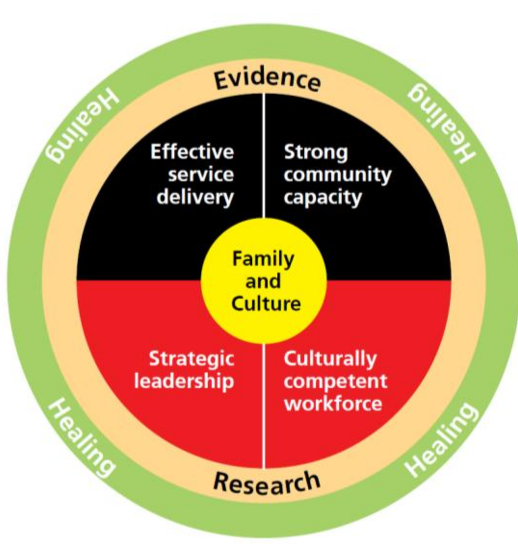
The *Aboriginal Family Health Strategy 2011-2016: Responding to family violence in Aboriginal communities* (AFHS) is a commitment of NSW Health to reduce the incidence and impact of family violence in partnership with Aboriginal people and their communities (NSW Department of Health , 2011). The AFHS consists of Aboriginal Family Health Workers (AFHWs) in Aboriginal Community Controlled Health Services (ACCHSs), non-government organisations (NGOs) and Local Health Districts (LHDs), and Aboriginal Family Health Coordinators (AFH Coordinators) in LHDs.

The aims of the AFHS are to:

- Reduce the incidence and impact of family violence in Aboriginal communities
- Build the capacity and strength of individuals and communities to prevent, respond to and recover from family violence
- Nurture the spirit, resilience and cultural identity that build Aboriginal families.

## Aboriginal Family Health Model of Care

The AFHS describes an Aboriginal Family Health Model of Care that has at its core Aboriginal family and culture and is comprised of four elements: Strategic Leadership, Effective Service Delivery, Culturally Competent Workforce, Strong Community Capacity, within a framework of healing and with a focus on evidence and research. The Model of Care is based on a coordinated and integrated response requiring leadership, collaboration and partnerships at state and health service level, co-ordination and genuine collaboration between the ACCHSs sector and government agencies. It also relies on well trained, resilient staff and localised community-based solutions building on community strengths and resilience. The following diagram illustrates the model.




Implementation of the AFHS is supported by the principles of Aboriginal Health: whole-of-life view of health, self-determination, working in partnership, cultural understanding, and recognition of trauma and loss.

The AFHS acknowledges the rights and diverse experiences of individuals, their families, and communities, and the need for flexible and tailored responses.

Responsibility for management and coordination of the AFHS has transitioned to NSW Kids and Families, however, for the period reviewed in this evaluation, the Strategy was led by the Centre for Aboriginal Health, NSW Ministry of Health.

## Policy Context

The AFHS is now being implemented as part of the NSW Kids and Families strategic plan, *Healthy, Safe and Well: a strategic health plan for children, young people and families 2014-24* (NSW Kids and Families, 2014). *Healthy, Safe and Well* provides a comprehensive planning and policy roadmap for NSW Health from preconception to 24 years of age, including pregnant women, babies, children, and young people in the context of their families and communities. *Healthy, Safe and Well* has a focus on addressing risk and harm and aims to build capacity to appropriately respond to victims of violence, abuse and neglect.

The AFHS is broadly supported through the implementation of key NSW Government plans and policies including:

- *The NSW Aboriginal Health Plan 2013-23*, which is focussed on changing the health system to ensure that policies and programs meet the needs of Aboriginal people (NSW Health, 2012)
- *It Stops Here*, the domestic and family violence framework that strengthens the NSW Government's approach to violence prevention, recognising the need for flexible responses to respond to the varied experiences of Aboriginal families and communities (NSW Government, 2014)

- OCHRE, Opportunity, Choice, Healing, Responsibility, Empowerment: NSW Government Plan for Aboriginal affairs: education, employment & accountability, which includes a commitment to develop genuine partnerships with Aboriginal communities and responses to trauma and healing that are informed by the experiences of Aboriginal people (NSW Government, 2013)

- *Keep Them Safe: A shared approach to child wellbeing* is the NSW Government's plan to improve the safety, welfare, and wellbeing of children and young people. *Keep Them Safe* aims to enhance the universal service system, improve prevention and early intervention services, better protect children at risk, support Aboriginal children and families, and strengthen partnerships with non-government organisations in the delivery of community services (NSW Department of Premier and Cabinet, 2009).

## Aboriginal Family Health Workers

Aboriginal Family Health Workers (AFHWs) are a core component of the AFHS. NSW Health currently funds 24 AFHW positions across NSW – these are located within two LHDs (4 positions), Justice Health (1 position), and eighteen NGOs (19 positions). AFHWs respond to their local contexts and deliver programs that aim to reduce the incidence of family violence in Aboriginal communities through prevention, early intervention and community development activities.

AFHWs provide a mix of individual and family support activities, including crisis support, advocacy and referral to other services. Their work also comprises broader community development and education strategies, with a focus on prevention and early intervention. Responding to local needs and contexts, they actively engage local communities, and incorporate healing and promotion of Aboriginal independence and empowerment. The programs implemented locally include shorter-term activities such as community events or camps and others include ongoing programs such as support groups.

AFHWs are a resource for supporting families experiencing violence, and provide local leadership in facilitating early intervention and prevention strategies. The AFHW role varies given the distinct differences of communities within NSW and the complex nature of family violence. The AFHW role maintains a strong focus on building rapport, listening and developing trust, assessing risk for children and adults, providing information on the nature of violence, providing advice on the rights of victims, making referrals and participating in case conferences.

The Operational Guidelines for Aboriginal Family Health Workers aim to ensure the workers are well supported in their role (NSW Department of Health, 2008).

## Aboriginal Family Health Coordinators

A second key element of the AFHS is a trial of Aboriginal Family Health Coordinator (AFH Coordinator) positions which were established in 2011-12 in four LHDs: Hunter New England, Mid North Coast, Northern NSW and Illawarra Shoalhaven.

The aim of the AFH Coordinator positions is to facilitate improved system planning and coordination of service delivery, and to provide linkage between the NSW Health system, non-government organisations and whole of Government initiatives addressing family violence in Aboriginal communities. This position coordinates efforts to reduce and prevent family violence in Aboriginal communities in a culturally

appropriate way to enable better access for Aboriginal people to a range of services. AFH Coordinators may support the work of AFHWs, but they do not have a coordination function for AFHWs.

AFH Coordinators maintain a local strategic leadership role in developing and sustaining an integrated service response to Aboriginal families who experience violence. AFH Coordinators provide mentoring and cultural supervision to Aboriginal and non-Aboriginal staff, establish and foster networks within the Aboriginal workforce, have an advocacy role within the health system and provide cultural awareness training as a strategy to support the cultural capacity of services.

The following table outlines the locations and organisations where the AFHWs and AFH Coordinators are based.

**Table 1: LHD, organisation and location of AFHW and AFH Coordinator funded positions at December 2014**

| Funded organisation | Position | Location | Type of service |
|---|---|---|---|
| **Central Coast LHD** | | | |
| Eleanor Duncan Aboriginal Health Centre | AFHW | Wyong | ACCHS |
| **Far West LHD** | | | |
| Maari Ma | AFHW | Broken Hill | ACCHS |
| **Hunter New England LHD** | | | |
| Hunter New England LHD | AFH Coordinator | Tamworth | LHD |
| Awabakal Newcastle Aboriginal Cooperative | AFHW | Newcastle | ACCHS |
| Biripi Aboriginal Corporation* | AFHW | Taree | ACCHS |
| Moree Community Health, HNE Health | AFHW | Moree | LHD |
| Tobwabba Aboriginal Medical Service Incorporated | AFHW | Forster | ACCHS |
| Toomelah Clinic, HNE Health | AFHW | Toomelah | LHD |
| Wallsend Campus, HNE Health | AFHW | Wallsend | LHD |
| **Illawarra Shoalhaven LHD** | | | |
| Illawarra Shoalhaven LHD | AFH Coordinator | Wollongong | LHD |
| Waminda | AFHW | Nowra | ACCHS |
| Justice Health (based at Waminda) | AFHW | Nowra | ACCHS |
| **Mid North Coast LHD** | | | |
| Mid North Coast LHD | AFH Coordinator | Port Macquarie | LHD |
| Goorie Galbans Aboriginal Corporation | AFHW | Kempsey | ACCHS |
| **Murrumbidgee LHD** | | | |
| Riverina Medical and Dental Aboriginal Corporation* | AFHW | Wagga Wagga | ACCHSs |
| **Northern NSW LHD** | | | |
| Northern NSW LHD | AFH Coordinator | Maclean | LHD |
| Bulgarr Ngaru Medical Service | AFHW | Grafton | ACCHS |
| Bugalwena^ | AFHW | Tweed Heads | LHD |

| Funded organisation | Position | Location | Type of service |
|---|---|---|---|
| **Western NSW LHD** | | | |
| Bourke Aboriginal Health Service | AFHW | Bourke | ACCHS |
| Centacare Wilcannia-Forbes# | AFHW | Narromine | NGO |
| Centacare Wilcannia-Forbes# | AFHW | Narromine | NGO |
| Centacare Wilcannia-Forbes# | AFHW | Bourke | NGO |
| Coonamble Aboriginal Health Service | AFHW | Coonamble | ACCHS |
| Dubbo Neighbourhood Centre | AFHW | Dubbo | NGO |
| Walgett Aboriginal Medical Service Cooperative Ltd* | AFHW | Walgett | ACCHS |
| Wellington Aboriginal Corporation Health Service | AFHW | Wellington | ACCHS |
| Yoorana Gunya Aboriginal Family Violence Healing Centre | AFHW | Forbes | ACCHS |
| **Western Sydney LHD** | | | |
| Aboriginal Medical Service Western Sydney | AFHW | Mt Druitt | ACCHS |
| **Southern NSW LHD** | | | |
| Intereach | AFHW | Deniliquin | NGO |

*Vacant position

^ AFHW on maternity leave (position not backfilled)

# Shared position – Centacare Wilcannia-Forbes is funded for two positions which are shared between three AFHWs.

## 1.2 Evaluation

The NSW Ministry of Health commissioned an evaluation of the AFHS to provide an overview of how the AFHS is implemented across NSW, focussing on the two key components of the program – the Aboriginal Family Health Program implemented by the AFHWs and the AFH Coordinators trial. The Cultural and Indigenous Research Centre Australia (CIRCA) was contracted to conduct the evaluation.

The objectives of the evaluation were to:

- Describe the implementation of the AFHS at the state and local level for the period 2011–2013[1]
- Describe the activities and outputs implemented through the AFHS and estimate the reach of services
- Identify achievements and challenges related to the four core elements of the Aboriginal Family Health Model: Strategic Leadership, Effective Service Delivery, Culturally Competent Workforce, and Strong Community Capacity.

[1] Some data included in the report are up to December 2014

# 2. Methodology

A mixed methods process evaluation was undertaken including interviews with AFHWs, AFH Coordinators and key stakeholders at the state and local level, analysis of AFHW data collection forms and AFH Coordinator reports and a document review. The methodology for the evaluation is further detailed below.

## 2.1 Evaluation questions

The evaluation sought to answer several questions which align with the evaluation objectives and relate to the four core elements of the AFHS. The following table outlines the evaluation questions and the corresponding section in the report that addresses the questions.

**Table 2: Evaluation questions and corresponding report section**

| Evaluation question | Corresponding report section |
|---|---|
| **Strategic leadership** | |
| How have the AFH Coordinators contributed to strategic leadership at the regional level? | Section 5 |
| Have effective strategic partnerships been developed at the state and regional level which facilitate an integrated approach to family violence? | Section 5 |
| **Effective service delivery** | |
| What is the relationship between the AFH Coordinators and the AFHWs? | Section 4 |
| What is the type and scope of activities implemented by AFHWs and AFH Coordinators in the areas of prevention, early intervention, crisis intervention, and community development? What is the estimated reach / uptake of each of these activities in the target population group? | Section 3 |
| How do the AFH Coordinators and AFHWs work with other local stakeholders (e.g. Aboriginal Community Controlled Health Services, Local Health Districts, Medicare Locals, and others) to improve service collaboration, co-ordination and integration of service delivery at a local level? | Section 4 |
| Are the service delivery tools (guidelines, policy, protocols, strategy, etc.) and program monitoring tools (data forms, etc.) sufficient to guide and monitor effective service delivery? | Section 4 |
| **Culturally competent workforce** | |
| How has the AFHS contributed to the development of a highly skilled, supported and culturally competent workforce able to address issues related to family violence in Aboriginal communities? | Section 6 |
| Is there evidence of increased knowledge, skills and capacity of AFHWs and AFH Coordinators to prevent and respond to family violence? | Section 6 |
| Have the workforce training components of the AFHS created further career development opportunities and pathways for participants? | Section 6 |
| Have AFHWs received appropriate, effective, and culturally safe supervision and support within their workplaces and regions? | Section 6 |
| **Strong community capacity** | |
| Do the initiatives implemented under the AFHS reflect local need and community ownership? | Section 7 |
| Is there evidence of increased knowledge, skills and capacity of Aboriginal communities to prevent and respond to family violence? | Section 7 |
| How do the AFHWs and AFH Coordinators engage with their communities, and how have these | Section 7 |

| Evaluation question | Corresponding report section |
| --- | --- |
| positions contributed to improved community capacity? | |
| **All strategy areas** | |
| Have the activities and outputs described in the Program Logic been implemented? | Appendix 2 |
| Are effective strategies in place to monitor the activities and outputs implemented under the AFHS? | Section 3 |
| What have been the achievements and challenges in Strategic Leadership, Effective Service Delivery, Culturally Competent Workforce and Strong Community Capacity at state and regional level? | Section 8 |
| What different models and approaches have been applied locally to implement the AFHS, and what are the strengths and weakness of these approaches? | Section 3 |
| Has the implementation of the AFHS been conducted in a culturally competent way that is acceptable to key stakeholders? | Section 8 |
| Is the overall AFHS and Aboriginal Family Health Model perceived to be appropriate and effective by key stakeholders? | Section 8 |

In order to answer these evaluation questions, the evaluation consisted of the following three data collection components:

- Qualitative interviews
- Review of monitoring/reporting data
- Document review.

Ethics approval to conduct the evaluation was received from the Aboriginal Health and Medical Research Council (AH&MRC) Ethics Committee in September 2014.

## 2.2 Qualitative interviews

Semi-structured interviews were conducted with AFHWs, AFH Coordinators, managers and team leaders of AFHWs/AFH Coordinators, chief executives of ACCHSs, and other key stakeholders, comprising NSW Kids and Families, NSW Health Education Centre Against Violence (ECAV), Justice Health, the Centre for Aboriginal Health and a previous Manager Violence Prevention and Care in a local health district.

Semi-structured interviews adopt open-ended questioning based on an interview guide and provide scope for each interview to pursue relevant information and additional avenues for inquiry. An initial draft of the interview guide was developed by the Centre for Epidemiology and Evidence in collaboration with NSW Kids and Families, and the Centre for Aboriginal Health. CIRCA further developed the interview guide in collaboration with the evaluation advisory group. A copy of the interview guide is at Appendix 1.

Invitations to participate in the evaluation were sent by the Director, Centre for Aboriginal Health and interviews were then arranged directly by CIRCA. Twenty-eight interviews were conducted with 45

participants including 17 AFHWs[2], 4 AFH Coordinators, 16 managers/chief executives of ACCHSs/team leaders and 8 stakeholders. Interviews were undertaken by CIRCA research consultants both face-to-face (at the ACCHS or LHD premises) and by telephone, and a mixture of individual, paired and small group interviews were conducted. The duration of the interviews ranged from approximately one hour for individual interviews to two and a half hours for group interviews. Where possible, interviews were conducted by Aboriginal research consultants. Interviews occurred between 22 October and 18 December 2014.

Prior to the commencement of the interview, participants were again informed that participation in the evaluation was voluntary, that feedback would remain anonymous and individual comments would not be directly linked to participants. Participants were also informed that if they did not wish to, or could not answer any questions, that the interviewer would move on to the next question. They were also provided the opportunity to withdraw their participation at any time. Participants were asked if they had any questions and after any questions were answered, interviewers sought verbal consent prior to the start of the interview. Additional verbal consent was sought for the interview to be audio recorded. Audio recorded interviews were transcribed, and notes were written for those that were not recorded.

The following table outlines the number and type of interviews conducted.

**Table 3: Qualitative interviews**

| Interviewee | Face-to-face | Telephone | Total |
|---|---|---|---|
| AFHW | 13 | 4 | **17** |
| AFH Coordinator | 4 | - | **4** |
| Manager/chief executive of ACCHS/team leader | 12 | 4 | **16** |
| Key stakeholder | - | 8 | **8** |

The scope of the evaluation did not include consultations with community members accessing the services, locally-based organisations that support the implementation of the AFHS (beyond the funded organisations) or the broader community. Although extensive qualitative data was collected from those involved in implementing the AFHS, future monitoring and evaluation could enable feedback from community members and other stakeholders in order to better understand the reach and impact of the AFHS from these perspectives.

## 2.3 Review of monitoring data

The evaluation included a review of completed annual AFHW data collection forms (see Appendix 3) and the AFH Coordinators evaluation forms (see Appendix 4). These data forms had been collected by the Centre for Aboriginal Health and completed by AFHWs or their managers annually and by AFH Coordinators six-monthly. The forms include both qualitative and quantitative information. The data

[2] At the time of the evaluation, three positions were vacant and one AFHW was on maternity leave. Two positions were shared across three AFHWs working with Centacare Wilcannia-Forbes.

collection forms were designed to review the activity of individual programs rather than to compare program activity across services or to aggregate data.

The review of the data collection forms highlighted limitations in the availability and consistency of the data. The data collection forms were not available for all services for both years.

The data collection forms that were reviewed for this evaluation were those made available by the Centre for Aboriginal Health and comprised 18 AFHW forms for the 2012-13 year, two AFHW forms for the 2013-14 year and four AFH Coordinator reports for 2012/13 (a mix of yearly and half-yearly reports). The quality of data reported across the services varied in the reports reviewed. Section 3.4 outlines the findings in relation to the data collection and monitoring.

## 2.4 Document review

Other relevant program documentation held by NSW Ministry of Health, AFHWs and AFH Coordinators, and other key stakeholders was also reviewed as part of the evaluation. This included: the AFHS, the Operational Guidelines for AFHWs, presentations given by the Education Centre Against Violence (ECAV) at the network meetings ('Aboriginal Trauma Informed Family Worker Model of Practice' and 'Aboriginal Family Health Worker Model'), ECAV Aboriginal Programs document, the position description for the AFH Coordinator in the Hunter New England LHD, a report of training conducted by an AFH Coordinator and flyers and brochures produced by AFHWs to promote programs and services (NSW Department of Health, 2011; NSW Department of Health, 2008; Education Centre Against Violence).

## 2.5 Analysis

Qualitative interviews with stakeholders were explored through thematic analysis incorporating the stages of open coding and axial coding. This enabled the identification of key themes to emerge and the richness of qualitative data to be explored.

A range of data sources (interviews, data collection forms and documents) were used in analysis and reporting. The approach to the incorporation of these sources was one of concurrent triangulation.

## 2.6 Results

Results of the evaluation of the AFHS are presented in sections 3–7. Section 3 describes the broad implementation of the AFHS, and sections 4–7 focus specifically on the elements of the Aboriginal Family Health Model of Care: Effective Service Delivery, Strategic Leadership, Culturally Competent Workforce and Strong Community Capacity. The implementation status of AFHS activities and outputs as described in the program logic was reviewed based on data collected from the interviews, data collection forms and document review; these findings are presented in Appendix 2.

# 3. Results: Implementation of the AFHS

This section answers the following evaluation questions:

**What different models and approaches have been applied locally to implement the AFHS, and what are the strengths and weakness of these approaches?**

**What is the type and scope of activities implemented by AFHWs and AFH Coordinators in the areas of prevention, early intervention, crisis intervention, and community development? What is the estimated reach / uptake of each of these activities in the target population group?**

**Are effective strategies in place to monitor the activities and outputs implemented under the AFHS?**

## 3.1 Activities undertaken by AFHWs

The interviews with AFHWs, managers, chief executives of ACCHSs, and AFH Coordinators, and analysis of the data collection forms indicate that all AFHWs implement approaches that cover the areas of prevention and early intervention, crisis intervention and support, and community development and education. These are described in more detail below. The approach taken to implementing the AFHS locally varies across the different locations in response to local community needs and often extends to providing support to clients for other complex issues such as mental health and drug and alcohol issues.

### Prevention and early intervention

Prevention and early intervention strategies focused on specific groups including women, men, families and students.

*Activities with women*

Support groups for women provide a safe environment to talk and share experiences, promote social inclusion and increase confidence and self esteem. As part of these groups, women undertake activities including art, gardening and crafts such as scrapbooking, sewing and quilting. Group attendees are often women who have been victims of family violence and information on available services and supports in the community is provided during these groups.

> *"The group have developed a passion for crafts especially their sewing, this in turn has developed their social skills, built on their self esteem and encouraged them to be proud and committed to developing other skills they need. The women have built strong friendships with other women and other activities and attended many other social gatherings." (AFHW data collection form)*

*Mums and bubs groups*

AFHWs noted that other programs such as playgroups, mums and bubs groups, Aboriginal Maternal Infant Health Services or other antenatal and postnatal support groups and programs provide avenues for identifying and working with at-risk families. AFHWs attend and engage with participants in these programs and are able to introduce other early intervention or prevention programs to these families and/or refer the families to other services and programs.

*Screening*

Some AFHWs also discussed having incorporated domestic violence screening into the annual health checks that their health service provides to the community. This included the development of a screening tool in consultation with psychologists and GPs to screen men in relation to attitudes towards healthy relationships. Others are coordinating training for the GPs in their service to implement routine domestic violence screening with their patients.

*Strategies that focus on engaging men*

Some services have implemented prevention and early intervention strategies that focus on engaging men in activities aimed at increasing their self esteem and building their sense of identity, in order to help them maintain healthy relationships with their families. Examples include programs and workshops through men's sheds or men's support groups that seek to build men's skills (e.g. in art, woodwork or stonework) and potentially assist in creating pathways to employment. As well, AFHWs have also supported men through job skills training courses.

> *"The men's self esteem and their sense of identity play a real crucial part in how they behave in a relationship - we do a lot of activities relating to their sense of identity and self esteem. And that can be very broad." (AFHW)*

Other examples of prevention and early intervention activities included providing parenting education to men's groups and supporting men (including fathers, grandfathers, uncles and older brothers) to be involved in Dads in School programs and attend school with their children who are starting kindergarten.

*Working with children and young people*

Many AFHWs reported working with children and young people in primary schools and high schools. This included the delivery of formal programs (e.g. Sista Speak and Love Bites), as well as informal talks and guest speaker discussions about healthy relationships, bullying, family violence, sexual health, sexual assault and drug and alcohol use. In some areas there is an arrangement with the schools where the AFHW and a counsellor or psychologist works with girls in the school on a regular basis, in some locations weekly. In other areas it occurs on a more irregular basis when opportunities arise. One service also supported a young women's mentoring program aimed at providing education and increasing awareness of family violence.

*Camps*

AFHWs reported organising and facilitating camps. For example at a camp for teenage girls, Aboriginal Elders attended the camp as mentors along with guest speakers including School Liaison Police Officers. During the course of the camp participants discussed issues such as healthy relationships, bullying, drug and alcohol use and misuse and safe sex practices. Additionally, some AFHWs reported organising annual women's camps in partnership with other local organisations, to provide a safe environment for

women to discuss issues and to raise awareness about local services. A range of organisations and service providers attended to discuss their services. For example, the NSW Police Domestic Violence Liaison Officer and the Aboriginal Community Liaison Officer discussed Apprehended Violence Orders (AVOs) and other domestic violence procedures; Court support officers through the Women's Domestic Violence Court Advocacy Service (WDVCAS) and legal officers from local legal services attended to discuss court procedures; and health service providers conducted health checks with attendees.

One male AFHW has also coordinated a camp for men in partnership with local and statewide sporting organisations to discuss the causes, triggers and consequences of domestic violence with participants.

The following table summarises activities recorded in annual reports provided by AFHWs in relation to providing prevention and early intervention programs and activities.

**Table 4: Prevention and early intervention activities implemented by AFHWs**

| Activity name | Target audience |
|---|---|
| **Groups/activities with women** | |
| Weaving the Net - Healing Day & Open forum | Aboriginal victims/ survivors of SA, DV/ FV |
| Domestic Violence Workshop | Women |
| Sexual Assault Workshop (Juvenile Justice) | Juvenile Justice Current Clients |
| Mums to mentors | Mothers |
| Wellbeing program | Women at risk of re-entering justice system |
| Healing House Activities | Women at risk of re-entering justice system |
| Health & wellbeing Pamper Day | Women |
| Mums and bubs, Antenatal Groups, young mothers group, | Expectant mothers and mothers of new babies |
| Women's Group | Women (usually women at risk/ affected by family violence) |
| Women's safe house group | Residents of the safe house and others who drop in |
| **Groups/activities with families** | |
| Playgroup | Families |
| Family Domestic Violence Camp | Families |
| Healthy Start team | Families |
| Day trip with Aboriginal community members and their children visiting early learning centres and preschools | Parents |
| Early Childhood Education Day – transition to school | Families |
| Yam – Up weekly group | All |
| **Activities with students** | |
| Love Bites | Students |
| Sista Speak | Students |
| Koori Girls healthy hygiene program | Parents and primary students |
| Therapeutic Horse Riding Programme | Students (at risk) |
| Stand Strong be proud | Students |
| Talk to TAFE students | Students |
| **Groups/activities with men** | |
| Men's Shed/men's groups | Men |
| Dad's in School | Fathers |
| Strong Aboriginal Men's workshops | Men |

Data source: AFHW annual data collection reports 2012-13 (18) and 2013-14 (2)

## Crisis intervention and support

For most AFHWs, a significant part of their work involves providing crisis intervention and support to community members experiencing family violence, with many in the interviews noting that listening is a major part of their role. AFHW annual reports indicated AFHWs had worked with 1241 clients, most of whom were women (657 or 75% were female and 216 were male clients) and children (436 clients).[3] Data was recorded on number of visits, but responses across locations varied dramatically with several services recording zero visits, and others recording 605 and 1128 visits over the year, as the approach to defining and counting visits varied.[4] For the 14 AFHWs that provided data for number of visits, a total of 3,562 were reported.

AFHW annual data reports also included an estimate of the percentage of their workload spent on providing services to victims and their families. Based on the 19 reports where this data was provided, the average proportion of time spent on providing services to victims and their families was 63%, and this range varied from 15% to 90%, although most estimated that between 60% to 80% of their workload was spent providing these services.

The types of support provided include:

- Assisting with crisis and temporary accommodation
- Support to access and attend clinical services
- Support to access and attend legal services
- Referral to other services/programs
- Court support to attend proceedings
- Support with Family and Community Services (FaCS) matters (e.g. case conferencing)
- Assisting with housing and housing applications
- Support with Centrelink.

### *Advocacy*

Advocacy on behalf of clients was also a key part of client support. In annual reporting, AFHWs indicate the number of representations or advocacy undertaken on behalf of clients. This information is provided in 19 reports (17 from 2012-13 and 2 from 2013-14), with an estimated total of 1810 representations made by these AFHWs. This included advocacy to a wide range of services including accommodation organisations (358), local courts / AVO (237), Centrelink (196) and other organisations (1019) such as general practitioners (GPs), medical services, schools, preschools, ACCHOs and other Aboriginal

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[3] The total clients in the report does not equal the total number of female, male and children clients, as some services did not count the children in their total, some did not indicate the gender of clients and some included children in their count of males and females.

[4] For some, visits counted appear to be outreach visits, for others, visits counted appear to be incidents of service provided to clients, thus producing varied numbers across the data.

community controlled organisations, local NGOs, police, correctional centres, justice services, mental health and community health services, and others.

*Case Management*

In providing crisis intervention and support, in the qualitative research AFHWs identified practices where case management meetings are conducted with staff from different program areas (e.g. mum's and bubs programs, midwifery, mental health, drug and alcohol) to develop a support plan for the client.

While not specific to the time of crisis, a lot of the work undertaken by AFHWs and AFH Coordinators in the LHD context is in relation to increasing the cultural competence of non-Aboriginal staff to work with Aboriginal families and supporting clinical staff to more effectively engage and treat Aboriginal clients during crisis intervention. This is predominantly through training, facilitating access to services for Aboriginal families, and supporting Aboriginal clients through mainstream service provision. LHD staff also noted they are able to use their networks to advise and assist colleagues to refer Aboriginal clients to appropriate services in other areas.

## Community development and education

AFHWs have been involved in organising community events to raise community awareness of family violence issues. The AFHW data collection forms 2012-13 (18) and 2013-14 (2) also indicate that AFHWs had coordinated activities around a range of community events. Some participants preferred informal approaches to community education where information is provided and interactive discussions are promoted in the course of involvement in other group activities.

Community development and education activities described by participants included:

- Organising White Ribbon Day events including a variety night, a ball, community BBQs and stalls in the park, raising awareness activities among Aboriginal men in the community and encouraging them to take the pledge against family violence.
- Organising Reclaim the Night, White Balloon Day and International Women's Day events, including developing T-shirts and other promotional materials for distribution
- NAIDOC celebrations
- Health Expo Day and Homelessness Day
- Community education programs facilitated by the NSW Health Education Centre Against Violence (ECAV) including Strong Aboriginal Men, Strong Aboriginal Women, Weaving the Net and Rural Responses to Aboriginal Family Violence. These programs were felt to have increased community confidence to speak out about family violence (discussed further in section 7.3).
- Topic-specific workshops had also been facilitated by the AFHWs, and a number of AFHWs had arranged for Lani Brennan to speak to community members about her experiences of violence and abuse.

- Life skills and vocational training and development including an Aboriginal Family Law forum, a computer course and the Rent It, Keep It program.

## 3.2 Client referral pathways

### Referrals received

The majority of referrals received by AFHWs were self-referrals (53%)[5], indicating a high level of engagement with the community by AFHWs. The remaining referrals came from a wide range of other services and workers. The AFHW data collection form does not itemise the full range of referral sources, however, in interviews AFHWs reported that clients are referred to their service through a variety of sources, including:

- Self-referrals
- Internal referrals (i.e. through colleagues within their health service or organisation)
- GPs
- Police (generally through the Domestic Violence Liaison Officer or as a result of a yellow card[6] referral)
- FaCS (Child Protection Services)
- Housing NSW
- Joint Investigation Response Teams (JIRT)
- Medicare Local
- Child and maternal health services
- Parent support services
- Other family violence, family support or community services/organisations
- Mental health and drug and alcohol services/workers
- Community Health Services
- Court support officers (e.g. WDVCAS)
- Legal services

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[5] Data based on 20 AFHW annual reports from 2012-13 (18) and 2013-14 (2)

[6] The Domestic Violence Proactive Support Service (DVPASS) model was developed and implemented by the NSW Police Force in 2003 to provide Local Area Commands (LACs) with a mechanism to refer domestic violence victims to specialist domestic violence services. Approximately 65 of 80 LACs across NSW use the DVPASS (also known as the Yellow Card system) in partnership with local services. AFHWs in some communities are the referral service for Aboriginal community members.

- Corrective Services (Probation and Parole)
- Schools
- Families NSW.

### Referrals made

In relation to referrals made to other services, based on the annual AFHW data collection reports AFHWs had mostly referred to housing (22%), Centrelink (16%), GPs (13%), crisis accommodation (9%) and mental health services (7%). Some AFHWs who were interviewed noted that their services had developed an intake and assessment process to review referrals and ensure clients are referred to appropriate services, usually within the health service itself (where available). An AFHW working in the LHD context was also developing an internal referral form for community health staff to refer to the AFHW and a flow chart to support the referral process. It was felt that this referral process would also help capture data in relation to the clients referred to the AFHW.

When AFHW's made contact with specific child protection organisations this was most commonly with the Community Services Child Protection Helpline (69 contacts), Health Child Wellbeing Units (28 contacts) and Family Referral Services (13 contacts).

## 3.3 Governance and coordination

Responsibility for management and coordination of the AFHS recently transitioned to NSW Kids and Families, however, for the period reviewed in this evaluation, the Strategy was led by the Centre for Aboriginal Health.

AFHWs and their managers were generally positive about the support they had received from the Centre for Aboriginal Health. However, in the period reviewed in this evaluation, a restructure and changing role of the Centre for Aboriginal Health meant that for a time central coordination was significantly reduced, network meetings did not occur and data compliance was not monitored. Some AFHWs and AFH Coordinators appointed during this period felt there was a lack of support and guidance centrally and issues with vacancies in some services and LHDs were not investigated and supported. Participant feedback indicated there was a lack of clarity around the implications of the change in management of the AFHS from the Centre for Aboriginal Health to NSW Kids and Families and the future direction of the AFHS. Along with these uncertainties, some organisations were also facing additional changes and resource constraints as a result of their organisational restructure. Interviewees suggested the AFHS requires a renewed focus on governance, and AFHWs requested greater information and contact from the Ministry.

Interviewees also felt there was limited central management of the trial of the AFH Coordinator positions at this time. Management at a regional level varied due to local management structures. Initial funding of the AFH Coordinators was for a three year period, following which funding was allocated on an annual basis. This situation led to uncertainty regarding the future of the role and as discussed in section 5.1, it was felt by participants that this made strategic planning for some Coordinators challenging.

## 3.4 Monitoring activities and outputs

The evaluation highlights that management and ongoing monitoring systems need to be strengthened and refined. As with many initiatives that address complex needs among families and communities, it is difficult to capture through program monitoring data the extent of the work being undertaken by key roles. Evaluation participants working within the LHDs identified limitations in the Community Health Information Management Enterprise (CHIME) system used in community-based settings across NSW Health. Specifically, it was felt that activities such as community engagement, supporting families through other services, working collaboratively with other organisations and community engagement activities were not easily captured. Similarly, AFHWs felt that stories of change for clients, families and communities were also not able to be adequately conveyed.

Further, on review of the specific data collection form created for AHFWs, the evaluators found similar limitations in this regard, as the data collected has not effectively captured the activities undertaken by AFHWs beyond formal prevention and education programs, and the numbers reached through clinical support. As such, these more qualitative and narrative data elements also need to be captured through the ongoing program monitoring.

The evaluation highlights a need for a template or process to support AFHWs and AFH Coordinators to collect ongoing monitoring data that can easily output data to meet biannual or annual reporting requirements. At the moment the AFHW data collection form is designed to be completed periodically, and it is up to AFHWs to collect the data requiring aggregation through their own systems. Some AFHWs commented that they had developed their own spreadsheets to assist in ongoing data collection. The lack of a practical template has resulted in variations in the way data is recorded and reported.

Ongoing program monitoring processes should also be designed in a way that allows for easy aggregation of data across locations, in order to understand the reach of initiatives across the whole AFHS. Lastly, any refinements to program monitoring will need to be developed through close consultation with AFHWs and AFH Coordinators to ensure that ongoing program monitoring is relevant, appropriate, user friendly and does not become an additional administrative burden for workers.

AFHWs, managers, chief executives of ACCHSs and stakeholders made some suggestions in relation to overall management of the AFHS. For example, it was suggested that receiving feedback on annual reporting would be useful. It was also suggested that visits from the statewide AFHS manager/s would be valuable in order to witness what is being implemented on the ground as part of the AFHS. Some AFHWs mentioned that this had happened in the past and it was felt to be beneficial.

## 3.5 Service gaps and challenges

### Service gaps

A lack of emergency or crisis accommodation was consistently cited as a barrier to successfully delivering services that meet client needs. Some participants, particularly those in smaller communities, identified a general need for crisis accommodation, with some indicating that they had taken clients to their own homes.

> *"I think if we could do with anything in the community it would be domestic violence accommodation. There's just none of that, so I think people, or victims, sometimes don't report domestic violence because there's nowhere for them to go, and if there's a domestic violence incident in the middle of the night, unless family members take them in, there's just absolutely nowhere." (AFHW)*

Others cited perceived impacts of the Going Home Staying Home reforms including the closing of some women's refuges and the changing of service criteria to include men experiencing homelessness as part of the funding of services which were felt to create more challenges for accessing accommodation for clients experiencing family violence.

> *"Because women refuges have closed around the place ... And the changes with the criteria now, it's not necessarily women would look at that as a safe option now because the target group for taking in those people has been extended to homeless men and women and so forth. So whereas it was just a women's refuge before now they're taking in homeless men." (AFHW)*

A shortage of services and programs to support men and a shortage of male workers across services were identified as a significant challenge to responding to family violence in Aboriginal communities. This was felt to be exacerbated by guidelines requiring referral to accredited programs only. Some also felt that existing men's groups do not, or do not adequately, address family violence issues. The gap in male workers was noted in the AFHS document as an area to be addressed through the establishment of additional male AFHW positions, however, this has not yet occurred.

> *"We can almost be subjecting some women to a risk of greater harm when their men are you know feeling more and more marginalised and they're not getting supported and then ... marriages, partnerships break down, he hasn't got anyone to talk to and he ends up doing crazy stuff ... we find it here all the time the men want to come and be part of restoration of whatever and can't. Yeah it's a big issue." (ACCHS Chief Executive)*

Similarly, the lack of alcohol and other drug rehabilitation services in some areas was cited as a challenge for AFHWs when supporting clients in crisis.

Those working in smaller and more remote communities identified that a lack of services across the board posed challenges for supporting clients, and some noted that available services may not always take clients for a range of reasons (for example, the complexity of their case), which they felt sometimes excluded their Aboriginal clients from accessing services. Distance was also cited as a challenge where one worker is servicing a range of Aboriginal communities in the region.

### Awareness of the AFHS

The evaluation suggests there has been a lack of promotion of the AFHS. As a result there is a low level of visibility of the AFHS in mainstream violence prevention initiatives and frameworks. There are opportunities for the AFHS to inform the work of LHDs and other agencies in relation to health and family health in Aboriginal communities more broadly.

*"I don't know that there's probably enough visibility about the strategy at a state level or at a district health service level..." (Stakeholder)*

It was noted that knowledge and awareness of the AFHS and the role of the AFH Coordinators across NSW Health is low. The AFHS was seen as particularly relevant for placing the issue of family violence in Aboriginal communities on the agenda of the LHDs and encouraging support for initiatives aimed at reducing its incidence and impact, and its visibility in this regard is particularly important.

In terms of performing their role and providing crisis intervention and support, it was seen as important that AFHWs are known in the community, while at the same time being careful not to label themselves as family violence workers. There was a belief that they should not over-promote themselves as family violence workers so community members can feel confident to approach them about sensitive issues, trust that the support they receive is anonymous and confidential, and avoid potential stigma for them or their family if they are seen to be receiving services or support from the worker. Some commented positively that the title Aboriginal Family Health Worker allows for a broad interpretation of their role.

*"So it's not standing out and saying that's the family violence worker and she's going into that house. So it gives people confidence ... Being titled Aboriginal Family Health Worker sometimes is a good thing ... it just leaves it open for people. They can just have a yarn about anything." (AFHW)*

## Funding for the AFHS

Chief executives of ACCHSs, managers, AFH Coordinators and AFHWs raised concerns around service gaps in relation to the funding of AFHWs, AFH Coordinators and male AFHWs. Some participants indicated there is a need for a more consolidated approach to family violence strategies across the different regions, and an increased workforce to implement the AFHS. As well, the evaluation highlighted a need for ongoing review to determine where additional positions should be funded under the AFHS. This is particularly relevant given the AFHS itself identifies the funding of additional AFHW and AFH Coordinator positions as a key component of the AFHS.

A limitation in relation to the amount of funding allocated to the AFHW positions was also highlighted by AFHWs, their managers and chief executives of ACCHSs. This was felt to have had an impact on the reach of services, the initiatives that AFHWs were able to implement and the difficulties in recruiting suitable candidates for the AFHW position. It was also noted that the amount of funding has not changed significantly for some time and this also limits what can be achieved by the funded services.

*"When the funding is given out you get the funding for the wage and the on costs but there's only a small bucket for [community development and education]. That limits what you can do in terms of the service delivery and engagement and [the AFHW] plans her year out dollar by dollar but it's generally done in partnership with a lot of other key stakeholders too, to ensure that there's financial viability around that." (ACCHS Chief Executive)*

# 4. Results: Strategic leadership

This section answers the following evaluation questions:

**How have the AFH Coordinators contributed to strategic leadership at the regional level?**

**Have effective strategic partnerships been developed at the state and regional level which facilitate an integrated approach to family violence?**

This section describes strategic leadership at the state and regional level. It identifies the contribution to strategic leadership by the AFH Coordinators through initiatives focussed on workforce development, networks and groups, advocacy in relation to the AFHS and community development and engagement. This section also examines the development of strategic partnerships, particularly interagency partnerships, to support an integrated approach to family violence.

## 4.1 The AFH Coordinators' role

There are four AFH Coordinator positions funded across NSW, in four different LHDs, and in different streams within each LHD, as follows:

- Hunter New England LHD - Violence Prevention and Care
- Mid North Coast LHD – Women's Health
- Northern NSW LHD - Aboriginal Health
- Illawarra Shoalhaven LHD - Violence Abuse and Neglect Services.

The number of AFHWs in each of the four regions with an AFH Coordinator position varies from one in the Mid North Coast LHD to six in the Hunter New England LHD.

Given the variation in region, organisational structure, and AFHW resources, it is difficult to generalise the findings from the evaluation in relation to contribution to strategic partnerships and leadership overall. The approach of each AFH Coordinator has also varied in response to the local environment, and this needs to be acknowledged when interpreting these evaluation findings.

The evaluation found that the AFH Coordinator positions are highly valued and are seen to contribute significantly to the implementation of the AFHS. Participants felt that the role is pivotal in supporting AFHWs at a local level, supporting the Aboriginal workforce more broadly across the LHD, improving the cultural competence and appropriateness of service provision to Aboriginal families, creating networks across the family violence service sector, and advocating for and being involved in decision making about violence prevention strategies and strategies to improve service delivery for Aboriginal families experiencing family violence.

## Workforce development

The feedback indicates that AFH Coordinators have significantly contributed to building the capacity of the sector to work with Aboriginal families in relation to family violence by coordinating training for both Aboriginal and non-Aboriginal staff within the LHD and within ACCHSs and other community organisations and services across the region. These have included training components in relation to child protection, responding to child sexual assault, sexual assault, domestic violence, AVOs and trans-generational trauma. Several AFH Coordinators noted that they would like to provide more education and training, for example with counselling teams and registrars in hospitals around trans-generational trauma, but that this is not possible because they are time poor.

AFH Coordinators are an avenue for advice and support for their colleagues working with Aboriginal families. They also provide cultural supervision and mentoring to Aboriginal and non-Aboriginal staff within the LHD, including managers and clinicians, and coordinate ongoing supervision for colleagues with other mentors. Participants noted challenges in finding suitable people to provide cultural supervision, while not relying too heavily on the same individuals.

> *"It's about support that's culturally relevant, that builds on some of the cultural strengths and its solutions and strengths based. So that it's not just about a debrief in terms of this is what happened to me today but this is some meaningful content and some strategies ..." (AFH Coordinator)*

The supervision provided to non-Aboriginal staff was perceived to build the cultural competence of the non-Aboriginal workforce. A few participants noted that some community health staff do not recognise the need for supervision and believe they are working well with Aboriginal families, but community feedback indicates otherwise, with some interviewees suggesting that this kind of cultural supervision should be mandatory for all non-Aboriginal staff working in Aboriginal programs.

It was felt that provision of cultural supervision and support by AFH Coordinators removed pressure or expectations from Aboriginal staff working alongside non-Aboriginal clinicians and other staff to provide cultural support and access to communities when this is not part of their role.

> *"Just because you've got an Aboriginal worker that you work in partnership with, doesn't mean that that Aboriginal worker is able to sort of give you that level of support. You can't expect that from that Aboriginal worker." (Manager)*

One AFH Coordinator reported being in the process of drafting cultural supervision guidelines that will be linked to the clinical supervision guidelines, in consultation with Aboriginal community Elders. It was reported that the Elders are very supportive of the guidelines and are assisting in identifying appropriate cultural supervisors working in government agencies in the region to provide support.

AFH Coordinators have developed or are in the process of developing a directory of services that provide health care and support to Aboriginal families. In one region, the directory has been put on the intranet in one hospital and provides information for primary and emergency health care staff on possible pathways for referring patients who are discharged. It is intended that this resource be rolled out to other hospitals in the LHD. In other regions, the directory of service contacts (including men's and women's services

with women's DV services embedded in the list to ensure safety) will be provided to clients as a wallet card contact list, or a resource (such as fact sheets) for health care staff and clients.

### Networks and groups

In addition to the service delivery networks outlined in section 5.1 below, AFH Coordinators have developed networks or peer support groups (both formal and informal) with Aboriginal staff within the LHD to provide a forum to debrief and discuss workplace challenges and to provide cultural support to one another. The groups also provide a forum for developing tools to respond to any issues that may arise.

> *"It's the cultural support ... It's actually talking about cultural issues that we come across within our workplace ... Sometimes you can go to your manager and they just don't understand the issue ... especially if it's cultural ... So it's a place where we can all come and ... say what was said without feeling intimidated ... and what we can all do together coming up with some solutions to that." (AFH Coordinator)*

The need for this support was strongly acknowledged, particularly due to the challenging and at times isolated nature of the work and the complexities of being part of the community. It was suggested that NSW Health could do more to support these workers in order to avoid vicarious trauma and acknowledge and support workers' own trauma.

> *"Networking and providing support to each other ... absolutely invaluable ... that the staff feel a connection with each other when they're working in quite challenging and isolated environments and I think just the forum where Aboriginal staff can be together without non-Aboriginal people in the room, to be able to talk about some of the complexities of working within a dominant culture ... and the complexities of having to work and live in communities that I think that many non-Aboriginal people find very difficult to understand and see. So it was a really safe environment for those discussions to occur." (Stakeholder)*

Some AFHWs felt that having an AFH Coordinator has reduced their sense of isolation in their role, and they appreciate having someone they can call who understands their role and who they can "bounce things off".

### Advocacy

The evaluation indicates that AFH Coordinators play an important role in advocating for family health and violence prevention strategies and initiatives across the LHD that reflect the needs of Aboriginal families and are culturally safe and appropriate. They are members of various LHD executives, committees and meetings and are often the sole Aboriginal voice in management meetings. As such, the AFH Coordinators are seen as a link between on-the-ground service delivery and senior management and the evaluation highlighted the importance of this element of the role. Participants expressed concern that if the AFH Coordinator role does not continue, the Aboriginal voice in higher-level meetings, which they felt are often mainstream-focussed, will be lost.

> *"A Coordinator has an important role in guiding the executive about decisions that have been made that reflect the needs of Aboriginal people, and that's a strong voice that sits within that*

*group to be able to say we need to be thinking about this, or that's not the way that we should be going on something..." (Stakeholder)*

Part of this advocacy role is highlighting the importance of having a coordinated response to family violence in Aboriginal communities. This includes ensuring that the responsibility is not placed on one person (e.g. the AFHW) or one service, and that different services take responsibility for providing culturally relevant, appropriate and accessible services for Aboriginal families and communities.

*"I think we've been really good at identifying that it can't just be [the AFHW's] responsibility to address Aboriginal family violence ... It needs to be organisational and interagency coordinated response because putting that responsibility on Aboriginal people or one particular service it's just not effective. It actually probably adds to the disadvantage rather than help it." (AFH Coordinator)*

However, the extent to which AFH Coordinators are able to perform this role depends on the framework for family health services the role is working within and the level of support from senior management for both the AFH Coordinator's role and the AFHS more broadly. The evaluation suggests that although the AFH Coordinators feel well supported by their managers, they receive differing levels of support from senior management, therefore the level of involvement in the executives, committees and meetings varies across the LHDs. This in turn means there is variation in the commitment of these groups to engage in issues raised by the AFH Coordinators.

### Community development and engagement

Community development and engagement activities have also formed part of the AFH Coordinators' role. AFH Coordinators engage with community through Elders' groups, women's groups, ACCHSs, land councils and other Aboriginal organisations. The AFH Coordinators are a conduit for building trust and rapport between NSW Health and Aboriginal communities and developing collaborative partnerships to support improved service delivery. AFH Coordinators engage with community in relation to identifying and addressing community needs, and developing approaches for raising awareness and equipping the community so they feel safer disclosing and reporting incidents of family violence.

AFH Coordinators have been involved in conducting workshops and training across their regions to raise awareness in communities, including the ECAV training programs such as Strong Aboriginal Men, Strong Aboriginal Women and Weaving the Net. AFH Coordinators have also played a role in supporting organisations and services to conduct women's groups, women's conversations and women's camps, as well as community events.

## 4.2 Strategic partnerships

As part of the AFHS, the development of strategic partnerships has rested mainly with AFH Coordinators. In addition to the partnerships and relationships formed as part of local service delivery outlined in section 5.2 below, it was reported that AFH Coordinators have developed strategic partnerships with government agencies, ACCHSs, universities and other organisations and services to facilitate an integrated and culturally appropriate and responsive approach to family violence; however this has occurred to varying degrees across the regions.

AFH Coordinators noted that they have worked in partnership with agencies at a local and regional level including FaCS (Out of Home Care and Child Protection), NSW Police, the NSW Ombudsman, Aboriginal Affairs, the Department of Education and Communities and ECAV, including working with Joint Investigative Response Team (JIRT) and Keep them Safe (KTS) teams and initiatives. The evaluation found that AFH Coordinators have been able to establish these strategic partnerships to varying degrees in their LHDs, and there are opportunities to enhance the focus on strategic partnerships. Working with agencies and organisations that have a different approach, particularly those that operate in an environment that allows for limited flexibility (e.g. JIRT, NSW Police) was identified as a challenge at times. Examples of initiatives undertaken through the partnerships developed by the AFH Coordinators have included:

- Looking at Aboriginal consultation and engagement protocols for JIRT teams across the district and partnering with NSW Police and FaCS to improve implementation
- Working with *Keep Them Safe* in relation to the care of newborns to ensure that culturally relevant tools were developed (through consultation with Aboriginal stakeholders including workers, liaison officers, Aboriginal health networks and Aboriginal child health networks) and implementing child protection training and policy compliance procedures for the LHD
- Assisting the NSW Ombudsman to coordinate a response to concerns raised by community members in relation to the identification of child sexual assault issues in two communities. This included working with local agency representatives from Aboriginal Affairs, FaCS, JIRT, NSW Police and the Department of Education and Communities.

Feedback also indicates that AFH Coordinators monitor data and trends in specific communities in order to respond to changes, for example, monitoring an increase in the number of Aboriginal children entering out of home care. AFH Coordinators then work with FaCS to identify what may be causing the spike in the data and consider what needs to be put in place in terms of supporting the community in relation to associated trauma and the impact on LHD services and workforce capacity.

AFH Coordinators discussed building relationships with ACCHSs to coordinate and facilitate better access to NSW Health services and provide resources to support the work these services are doing in relation to family violence. This has included building capacity to support community needs but also relationship building to overcome some traditional barriers to Aboriginal organisations working with government agencies including NSW Health.

Another initiative involved a partnership aimed at building the cultural capacity of the clinical health workforce. A memorandum of understanding was developed between the LHD (via the AFH Coordinator), a local Aboriginal women's group, a local women's service and a university. The agreement involved providing an avenue for medical students to connect and engage with the local Aboriginal community with a view to enhancing their capacity for culturally competent treatment of Aboriginal families in the future. Through the agreement, students are given an opportunity to meet with Elders, learn about local culturally significant sites and hear about the issues confronting Aboriginal families and communities through attending weekly women's and men's groups.

High staff turnover and restructuring within LHDs were cited as barriers to meaningful and lasting partnerships with Aboriginal services at a regional level. It was felt that high turnover leads to a lack of continuity and prevents the establishment of ongoing relationships between LHD staff and ACCHSs.

## 4.3 Challenges

Given the high value placed on the work of the AFH Coordinators, it is not surprising that there was significant concern among those consulted that the AFH Coordinator position may not be re-funded.

> *"It [the AFH Coordinator role] has made a big difference because we get to network with all the other service providers in our area and we find out what's going on in every different community and [AFH Coordinator] is always there to support us with whatever help we need and to guide us in the right direction ... It's a shame too because I think they're looking at the Coordinator roles and we don't know if they're going to continue on next year. So it will be a big loss if we lose our Coordinators for our different areas." (AFHW)*

Challenges were also identified in relation to the AFH Coordinator position that is based on one person working across the LHD. Given the size of the LHDs, the disparate nature of some of the communities they service, and the many competing demands on the AFH Coordinators, it was felt there are clearly limitations on how much one person can achieve. For some, these challenges highlighted a need for more than one AFH Coordinator position across some of the LHDs.

Participants reported that uncertainty around the AFH Coordinator positions has made forward planning challenging and limited what can be achieved because they are pilot positions. This was felt to have a negative impact on building relationships and delivering strategic leadership. As a result, some AFH Coordinators have focussed on putting mechanisms in place that are self-sustaining, while also being clear with communities that the position may not be ongoing, and about what is achievable in a limited amount of time.

> *"That in itself becomes a trauma ... that's why they [Aboriginal communities] have these ongoing trust issues, especially with government departments because these workers are continuously coming out saying 'no, we really want to get to the root of these problems, we want to support you, what can we do?', and then fantastic programs or initiatives start and then they're not maintained." (AFH Coordinator)*

# 5. Results: Effective service delivery

This section answers the following evaluation questions:

**What is the relationship between the AFH Coordinators and AFHWs?**

**How do the AFH Coordinators and AFHWs work with other local stakeholders (e.g. Aboriginal community controlled health services, Local Health Districts, Medicare Locals, and others) to improve service collaboration, coordination and integration of service delivery at a local level?**

**Are the service delivery tools (guidelines, policy, protocols, strategy, etc.) and program monitoring tools (data forms, etc.) sufficient to guide and monitor effective service delivery?**

This section describes service delivery with reference to the relationship between the AFHWs and the AFH Coordinators and the local and statewide networks. Local service delivery and coordination mechanisms are described and application of service delivery tools, in particular the Operational Guidelines for Aboriginal Family Health Workers are reviewed.

## 5.1 Relationships between AFHWs and AFH Coordinators

Participant feedback indicates that generally AFHWs and AFH Coordinators had developed good working relationships. For some, connection has been limited to the network meetings, with several noting that although usually conducted every six months, a network meeting had not been conducted in over a year.[7]

### AFHW Networks

Some AFHWs reported that they were in contact with other AFHWs both within their region and across NSW to share ideas and discuss experiences. They noted that they had built relationships through attendance at network meetings and participation in the Certificate IV in Aboriginal Family Violence, and in some cases, the Advanced Diploma in Aboriginal Trauma Counselling. These forums were all highly valued opportunities for connecting with others. As noted in section 3.1, a few AFHWs have worked together to coordinate events within their region.

> *"I think it's like information sharing, especially in the network meetings and through the ECAV training. So just the information sharing and the support and – I think just sharing ideas, too, of what works in their community, what we do in ours and what – they might be doing something that I haven't even thought of and think, oh, yeah, maybe that could work in ours." (AFHW)*

AFHWs found the network meetings valuable, and suggested that management should aim to address some of the barriers that AFHWs face in attending these meetings. Funding constraints were identified

[7] A network meeting was held at the end of November 2014, so participants interviewed in October were not aware that a network meeting was scheduled (this was true for 19 participants).

and it was suggested that the meetings could be held in regional locations from time to time to alleviate some of the travel time and costs for some, and to provide an alternative forum to Sydney. It was also felt that this would provide an opportunity for site visits.

### AFHWs and AFH Coordinators

The evaluation found that the way that AFHWs and AFH Coordinators work together varies across the regions. Each AFH Coordinator is in a unique position according to the number of AFHWs working within the region (both within LHDs and ACCHSs), the number of communities the region covers, the size and the geographical spread of the region, and the unique circumstances of the LHD. In two regions, the AFH Coordinators work closely with the AFHWs while in the other two regions they are in the process of establishing relationships. It was noted however that networking opportunities are limited in these other regions given there are only one or two AFHWs, and it was felt that implementation of the AFHS would be enhanced if more AFHW positions were funded in these regions.

> *"But when you look at the dynamics ... the regions they [the AFH Coordinators] are covering, they're different ... totally different."*

In one region, the AFH Coordinator convenes an Aboriginal family violence prevention network which involves the AFH Coordinator, the AFHWs working across the region (including within the LHD and in ACCHSs) and other Aboriginal workers working in violence prevention services such as child and sexual assault. The network meets approximately five times per year and provides a forum to discuss ideas and improve service delivery for Aboriginal families across the region. It was also noted that the network offers an opportunity to share templates and processes developed by AFHWs that can be further developed and utilised by the network. The feedback indicates that the network is highly valued among those who participate. A further example was given from another region where the AFH Coordinator works with the AFHWs to coordinate and facilitate community education workshops with communities across the region.

The evaluation indicates that there may be a lack of clarity about how or whether AFH Coordinators should be working with AFHWs, particularly those working within ACCHSs, and there are opportunities to enhance the relationship among AFH Coordinators and AFHWs in some regions.

> *"And I don't ever think when these pilot roles came out there was ever a clear direction that [AFH Coordinators] had to really work with the family workers." (Manager)*

Some AFHWs in areas where there is no AFH Coordinator position indicated a desire to meet with other AFHWs at a regional level.

### AFH Coordinator Networks

AFH Coordinators reported that they are in regular telephone and email contact and support each other within their roles. In addition to informal contact, the AFH Coordinators teleconference bimonthly and discuss the initiatives they have been implementing and tools they have developed. The AFH Coordinators also have a separate meeting as part of the statewide network meeting.

*"We're all happy to share what we have, and I think we have a really good relationship." (AFH Coordinator)*

## 5.2 Local service delivery and coordination

The evaluation indicates that on the whole, AFHWs and AFH Coordinators work in a coordinated manner with other local services. Almost all AFHWs indicated that they attend and work through inter-agency networks, and many noted they are part of local DV collectives or working groups, monitoring committees or action teams. In some regions, the AFH Coordinator is also a member of these collectives. These groups include people who are working with clients who are experiencing family violence and generally meet monthly to discuss service coordination, and work together to organise and promote events and facilitate community development and education initiatives. Some AFHWs have been responsible for establishing the collective in their community. Further, some AFHWs are members of consultative committees of other agencies, and AFHWs working in LHDs also participated in meetings with other internal teams.

In 2012-2013, the 18 AFHWs who submitted annual reports attended at total of 282 external network meetings (an average of 16 per AFHW annually). The range of networks and interagency meetings attended included those relating to domestic violence, working with children and families, local service networks, community health, government services, referral, violence prevention and education. Several networks identified were Aboriginal specific.

A few AFHWs also noted that these networks have led to the consideration of a number of initiatives that are currently being explored. Examples included opening a crisis centre for women and their children experiencing family violence, and providing separate access to the Emergency Department and a special room for women who have been sexually assaulted or who have been the victims of family violence.

AFHWs and AFH Coordinators indicated that they work in partnership with many services and stakeholders across the community including representatives from NSW Police, Family and Community Services, Joint Investigation Response Teams, Medicare Local, ACCHSs, Intensive Family Based Support Services, Community Health teams, refuges, child and maternal health services, child and family services, DV counselling services, primary health teams, women's health centres, other community services/organisations, court support officers (WDVCAS), Probation and Parole, Families NSW, Aboriginal legal services, youth services, local councils and schools.

Informal approaches to building relationships with other services were also noted, with some noting that these can be particularly important for building more meaningful relationships with these services.

*"Calling in and saying 'how's it going?' ... showing your face." (AFHW)*

Many AFHWs indicated a commitment to working collaboratively with key local stakeholders with some noting that partnerships are strengthened when all parties are working towards the same goal of ensuring that clients receive the services they need.

*"We're all here to make sure our clients receive the services they require. And if there are gaps in our service, to try and work better together to make sure some of those gaps are filled*

*... if you can build better partnerships with services ... to make sure our clients receive the service that they need ... a collaboration for the final outcome for clients." (AFHW)*

It was also noted that building networks and working collaboratively and in partnership with other services is a necessity in smaller and more regional communities given limited resources, and most felt this was generally working well.

Although AFHWs and AFH Coordinators reported good working relationships with other services and stakeholders, a number of challenges were identified in relation to working collaboratively and coordinating service delivery with other services. These included high staff turnover, resulting in the connections made with one worker needing to be re-established with new staff, and people being protective or territorial of their clients (although it was noted that this was not common). A lack of continuity in funding for the sector more broadly and competition for limited funding were also cited as barriers to building effective partnerships.

*"It's really hard to have open transparent partnerships with services when people are worried about who's going to get funding, and sharing ideas and working collaboratively together when ... we had had some conversations with an organisation about a whole heap of programs and walked out to see a flyer on the table here and they've gone and done what we said we were going to do together. You know you just think what's that about? And that's them trying to cement themselves and get all the runs on the board for government. So it's really, really hard." (ACCHS Chief Executive)*

There was also some concern that increasingly mainstream organisations are being funded to deliver Aboriginal health and family health programs, and that they are not equipped to appropriately engage with the community. It was felt that these organisations have to turn to Aboriginal organisations and ACCHSs to access clients. These stakeholders felt that government could foster more meaningful local partnerships through localised funding models.

## 5.3 Service delivery tools

The key AFHS tools, namely the Operational Guidelines for Aboriginal Family Health Workers (Guidelines) and the AFHS itself, were felt to be highly relevant and useful. AFHWs and AFH Coordinators reported using these tools as a reference in guiding their work and how they undertake their role. Both the content and the language used were appreciated by participants, with positive references made in relation to the detailed information and practical examples provided.

A key strength of the Guidelines was that they provide flexibility to adapt approaches to particular communities or groups. This was a strong theme in the feedback provided, and was much appreciated by AFHWs and AFH Coordinators as this flexibility ensured the Guidelines are relevant and appropriate. Outlining the process of early intervention, crisis work and then referral was also seen as a key strength in clearly stating the parameters of the roles. One worker had also used the Guidelines to validate and advocate for the approach they were taking within their organisation.

*"I think the good thing about the guidelines is their ability to be flexible in terms of how you deliver it to the particular target group." (AFHW)*

AFHWs and AFH Coordinators noted that the AFHS document helped guide them in their roles, and had been used as an education tool to share with others. The AFHS was also used as a resource by some in designing programs and developing implementation tools such as action plans and operational guidelines.

> *"The strategy is really good ... Like you know what's in the strategy, but it's [also] a good tool to share out and show others around working in this context with managers and workers." (AFH Coordinator)*

AFHWs and AFH Coordinators referred to the Guidelines and AFHS document in an ongoing manner, highlighting that these tools continued to be a valuable resource, even for those who had been in their role long term. Active engagement with and use of these tools provides further evidence of their effectiveness in guiding service delivery.

> *"Well I guess you're just guided by them [the AFHS and the Operational Guidelines] in how you work. And if you have any issues you can refer back to them to make sure." (AFHW)*

Some participants noted that they had used the reporting tool designed for AFHWs and AFH Coordinators to further guide them in their role in relation to the types of programs and activities they were expected to implement.

A few AFHWs had shared additional resources and tools they had developed with one another. For example, one AFHW shared an Excel spreadsheet they developed with another AFHW to assist with data collection and monitoring client contact and activities. Suggestions were made for further improving the service delivery tools available and facilitating greater sharing of tools and resources between AFHWs and AFH Coordinators. These included creating a central site where relevant resources could be accessed (e.g. fact sheets for clients), and creating a generic resource or pamphlet that workers or organisations could adapt and use. AFHWs who had been employed more recently also discussed the initial steep learning curve when they started in the role, so there may be opportunities to support these AFHWs by providing regular update emails, having a site where AFHWs can connect with each other and post questions, and providing a buddy who is an experienced AFHW.

# 6. Results: Culturally competent workforce

This section answers the following evaluation questions:

**How has the AFHS contributed to the development of a highly skilled, supported and culturally competent workforce able to address issues related to family violence in Aboriginal communities?**

- Is there evidence of increased knowledge, skills and capacity of AFHWs and AFH Coordinators to prevent and respond to family violence?
- Have the workforce training components of the AFHS created further career development opportunities and pathways for participants?
- Have AFHWs received appropriate, effective, and culturally safe supervision and support within their workplaces and regions?

This section examines the development of a skilled, supported and culturally competent workforce. It describes opportunities for the AFHS workforce to build knowledge, skills and capacity through both formal training and opportunities to learn in the role which also provides the opportunity to building the cultural competence of non-Aboriginal staff. This section also describes career pathways and development and the provision of supervision and support particularly for AFHWs.

## 6.1 Knowledge, skills and capacity

### Formal training and skills development opportunities

Through the AFHS, AFHWs and Coordinators have had access to a range of training opportunities relevant to preventing and responding to family violence in Aboriginal communities. Training accessed has included training offered by the NSW Ministry of Health and, for AFHWs, additional training offered through ACCHSs they work within.

The Certificate IV in Aboriginal Family Health (Family violence, sexual assault and child protection) is a nationally recognised training program designed and delivered by the Education Centre against Violence. It is compulsory for AFHWs to have either completed or enrolled in the first available Certificate IV course as part of their role.

The Certificate IV in Aboriginal Family Health has provided an opportunity for the AFHW workforce to develop knowledge and skills in relation to power and control in the context of family violence, sexual assault and child protection in Aboriginal communities.  Undertaking the Certificate IV was seen as a highly positive element to the AFHW role by both the AFHWs themselves, and others interviewed for the evaluation. The skills and knowledge gained through the course were described as invaluable in preparing AFHWs to undertake their work with communities, increase their knowledge and skills, and in turn improve AFHS outcomes for clients and communities.

*"My confidence in myself and my role for the community is increased a great deal since doing that [Certificate IV] training ... I feel more confident and I have more knowledge around the issues that affect my role. So it does help me to give a better service for clients in the community." (AFHW)*

The Advanced Diploma of Aboriginal Specialist Trauma Counselling explores the importance of Indigenous worldviews in responding to individual and collective trauma experiences; providing an alternative to traditional Western paradigms of therapeutic intervention and service delivery. The Advanced Diploma of Aboriginal Specialist Trauma Counselling was discussed by several participants. Those who had completed the Advanced Diploma felt it was highly relevant and better equipped them in their roles. These participants felt that it should be recommended (or even required) that all AFHWs complete the Advanced Diploma, and that this requirement would also help AFHWs gain management support to complete the training. This would provide them with the requisite skills in community development and trauma-informed responses that are necessary to facilitate healing and respond to the complexities family violence.

Along with Certificate and Diploma level courses, AFHWs also undertook a wide range of short courses, seminars and workshops to assist them in their roles (one to five days duration) as outlined in the table below.

**Table 5: Short courses undertaken in 2012-13**

| Topic | Course |
|---|---|
| **Mental health** | Accidental Counsellor, Advanced DV counselling, ASSIST (Applied Suicide Intervention Training), Smart Recovery |
| **Family violence training** | Children and Domestic Violence Seminar, Loves Bites, Rural Responses to Domestic Violence |
| **Law** | Family Law workshop, Law Access forum |
| **OH&S** | First Aid, Manual Handling |
| **Child protection** | NSW Aboriginal Health Child Projection & Child Wellbeing facilitator training, Child Protection training |
| **Sexual assault and sexual health** | Brave Hearts Workshop, Sexual & Reproductive Health workshop |
| **Working with Aboriginal communities** | Including cultural healing, self care and cultural approaches - Red Dust Healing, Our Journey to Respect, Traditional Indigenous Games Training, Lateral Violence Training, Yarning Circle Facilitator Training, We Al-li Program |
| **Other** | Dementia Care, Human Rights, Quality Use of Medicines |
| **Young people** | Identify & Respond to Young People at Risk (Facilitator Training), Youth Mental Health First Aid, Shire for Kids, Parent Child Services Team Gathering |

Data source: 2012-13 annual reports completed by 17 AFHWs

Other training identified through qualitative feedback from AFHWs included Through Young Black Eyes (Family Violence Training), through the Secretariat of National Aboriginal and Islander Child Care and Responding Appropriately to the Victims of Domestic Violence. AFH Coordinators were also able to access training to support the leadership aspect of their role, such as Certificate II Aboriginal Leadership training and on-the-job training in recruitment.

Overall, it was clear that the skills, knowledge and capacity of AFHWs and AFH Coordinators increased through their employment in these roles. The training and skills development opportunities provided to AFHWs and AFH Coordinators were seen as a key strength of the AFHS, contributing to positive outcomes for the staff themselves as well as increasing the effectiveness of the AFHS for clients and communities.

> *"The training and the position has really opened my eyes to how much of an effect and an impact it [family violence] has on our communities and our people." (AFHW)*

Some of the AFHWs indicated that they planned to build on the qualifications and knowledge gained by undertaking further tertiary studies, such as undergraduate or postgraduate studies in social work or psychology. An example of this is the Graduate Certificate in Human & Community Services (Interpersonal Trauma) which is a partnership with ECAV and Faculty of Social Work, Sydney University. It is a one year postgraduate certificate course that will provide a professional pathway, for Aboriginal students in particular, to a Masters of Social Work.

> *"In terms of being genuine about wanting to build workforce capacity for Aboriginal people and opportunities, that's the ultimate ... to be able to actually get to a bachelor level qualification that allows the person to have a whole range of opportunities for workplace placement." (Stakeholder)*

The importance of the NSW Ministry of Health and funded organisations supporting the Aboriginal workforce to study and continue to develop skills and knowledge was noted.

## Learning in the role

While the training opportunities were identified as a key element of skills and capacity development among participants, the opportunity to learn and gain knowledge in the roles was seen as very significant. This went beyond just academic knowledge, with participants speaking about more personal aspects of change they have noted within themselves through what they have learned while being in the role, such as increased confidence, and changes in their values and attitude.

> *"I think it's amazing, honestly. I mean, I look back now and see how green I was when I came into the job, not knowing all that much ... Even my values and my beliefs have been [changed], it's a complete turnaround ... The things that I've learned, how to sit down and talk to people and listen, and I have knowledge now about where I can send them, how to get the best support for them and who I can contact to help them." (AFHW)*

The impact of the role in developing skills and increasing confidence was a strong theme. Increased confidence was identified as having both a positive personal impact for AFHWs and AFH Coordinators, as well as a positive flow on effect for the community, where the increased confidence of the AFHWs further enhanced their ability to influence positive change within the communities. Increased confidence in liaising with other services, such as meeting with management from different services, was also noted.

> *"We do need to bring awareness to the community around violence because it was always not discussed ... The training and being in the role for so long gives me the confidence to*

*challenge that thinking with the community members ... It's certainly given me a lot of skills. It's probably made me a bit more confident in just talking about different things ... before I used to be very withdrawn and very shy, but now I feel that I'm not like that at all." (AFHW)*

### Building the capacity of others

The reach of training and skills development extended beyond the staff employed under the AFHS. Specifically, AFHWs also spoke about their role in increasing the capacity of other staff within their organisations to respond to family violence, as well as building the cultural competence of non-Aboriginal staff. Examples included AFHWs working in ACCHSs and LHDs arranging ECAV training (including child protection, child sexual assault and DV training) for other staff in their organisations or LHDs, AFHWs putting up a communications board with relevant cultural information, and AFHWs providing cultural support or guidance to non-Aboriginal colleagues.

This aspect of the AFHW role increased the capacity of AFHWs to train others, provide supervision and undertake capacity building. As discussed in sections 5.1 and below in 6.3, a key part of the AFH Coordinator role was to support AFHWs and other Aboriginal health workers to undertake this capacity building role amongst their colleagues.

*"One of the things was to try and build the capacity of some of the staff that [the AFH Coordinator] provided supervision for ... [for them] to then provide supervision for their colleagues in their location, kind of build the capacity of the workforce." (Stakeholder)*

It was also recognised that capacity building across the workforce in relation to cultural capacity was an area that required further work and development, and significant time investment, and time spent on this took time away from other parts of the role. The importance of continuing to work with other organisations to promote culturally safe approaches was noted, particularly given the sensitive and potentially traumatic nature of family violence and child protection.

*"It's more around can you let us have an opportunity to share what we know about this community so we're not re-traumatising them through programs ... If they're talking about issues of trauma and family violence and child protection without having us weaved through that process they can open Pandora's box sometimes." (AFH Coordinator)*

## 6.2 Career pathways and development

AFHWs and AFH Coordinators felt that the experience, training and skills development gained through their roles were seen to contribute to enhanced career opportunities and pathways, and assist in achieving career aspirations. Participants also felt there was scope for growth and skills development within their current role and the opportunities to apply further education to the work they do.

Participants felt that the skills and capacities they had gained in their role would be relevant for their career development. This included the specific skills gained through training (e.g. counselling), as well as general skills such as enhanced understanding of the community, improved capacity to respond to cultural diversity, and improved knowledge of different approaches to working in this sector. Participants

spoke of the skills that they had gained in their role as having "set me up really well" in terms of career development.

> *"It's helped me develop a lot of knowledge ... it's taught me a lot about family violence and trauma-informed issues ... I got the opportunity to move onto something different and this has helped me 100%, this really has. It gave me certificates I can take with me to a different job." (AFHW)*

Participants noted the importance of career pathways for AFHWs, and the AFH Coordinator position itself was seen to create pathways and offer opportunities for career progression as it was a management level position. The AFH Coordinators were also seen as role models for potential career pathways for Aboriginal people within health. It was identified that the loss of these positions would also mean the loss of this career pathway, particularly as there were not seen to be a lot of Aboriginal management positions in the health services sector.

> *"I suppose it's that role model as well, like, we can achieve to actually go on to be a AFH Coordinator, gives us that career path as well." (AFHW)*

The skills built among AFH Coordinators in relation to management training (e.g. Certificate II Aboriginal Leadership training and training in recruitment) were seen as valuable for future management roles down the track.

> *"I think in these kinds of roles it's really important to have that career model– one, they're progressing their career, but secondly they're always maintaining their skills so that they're feeling confident about what they're actually doing." (Manager)*

## 6.3 Supervision and support

AFHWs generally indicated that they felt well supported in their roles. A range of supports were identified, and the combination of these was a key contributor to overall feelings of being well supported. Support was received from the funded organisations (including their team and managers), AFH Coordinators, as well as ECAV and the Centre for Aboriginal Health. In relation to formal supervision and debriefing sessions, 17 workers who provided annual reports for 2013-14 indicated they received a total of 132 professional supervision sessions (average of 7.7 sessions per AFHW annually), and 77 debriefing sessions (average of 4.5 per AFHW annually).

For AFHWs a supportive team was identified as a key element that reduced the sense of isolation in their role, which is significant given most AFHWs were the only ones in this role in their organisation. Some did, however, note the challenges in being the only AFHW given they dealt with many issues that they felt their co-workers could not understand.

> *"I know I'm supported, but ... I don't have another person doing the same job as me that I can sit down and go this has happened today, this is how I'm feeling. I don't think anybody else not doing that job can understand." (AFHW)*

Given this isolation, the role of the AFH Coordinators in providing supervision has been a key element of the AFHS. As previously indicated in section 4.1, AFH Coordinators play a crucial role in cultural

supervision, with this supervision and support extending to Aboriginal workers within LHDs more broadly. The role of providing cultural supervision was identified to be a key part of the AFH Coordinator role, as well as a challenge due to elements such as the time it took to build connections and undertake cultural supervision, as well as overcoming barriers when workers within the LHD may be resistant or unfamiliar to cultural supervision. The value of cultural supervision in creating a safe space for Aboriginal workers to share was highlighted, as was the potential for supervision to bring workers and services together across the LHD.

> *"I know that [AFH Coordinator] provides quite a significant amount of supervision to various Aboriginal violence prevention workers within the district ... She's provided so much support to so many because there's so little out there." (Stakeholder)*

Other supportive strategies for overcoming isolation for the AFHWs were having a manager who is available and supportive, and being involved in other groups or networks of Aboriginal health workers.

> *"So it's just that open communication channels that we've got going, support networks, whether we want a debrief, find out what's going in the community, both, I suppose, work-related and not work-related because we sometimes find that interconnects because of the family issues." (AFHW)*

The need for AFHWs to have strong supervision and support was highlighted by participants given the difficulty of the work they undertake, and the complexities of being part of the community within which they work. AFHWs spoke of the difficulty of setting boundaries and being clear to community about what their role includes (including their skills and capacities), while at the same time balancing this with community needs and their desire to contribute to positive outcomes for clients and families.

> *"It's hard to say no. I always say, I'm an Aboriginal worker. My hours don't stop after five o'clock, or on the weekend, because that seems to be when it all happens." (AFHW)*

# 7. Results: Strong community capacity

This section answers the following evaluation questions:

**How do the AFHWs and AFH Coordinators engage with their communities, and how have these positions contributed to improved community capacity?**

**Do the initiatives implemented under the AFHS reflect local need and community ownership?**

**Is there evidence of increased knowledge, skills and capacity of Aboriginal communities to prevent and respond to family violence?**

Section 7 looks at the development of community capacity including the processes of engagement to understand community needs and how AFHS initiatives reflect local need and ownership. This section then describes how these initiatives have built community knowledge, skills and capacity to prevent and respond to family violence identifying evidence of achievement in this area.

## 7.1 Process of engagement to understand community needs

The interviews explored the level of community engagement and perceptions of the impact of this engagement on community capacity, and the ability of the AFHWs and AFH Coordinators to respond to community needs. AFHWs and AFH Coordinators discussed approaches used to identify community needs, and to engage with community members.

Most AFHWs and managers consulted with those accessing the service to identify needs and how the service can best meet these needs. In most cases identifying community needs and community consultation was conducted in an informal way, which was identified to be appropriate given the sensitive nature of family violence and the need to be responsive. This approach enabled workers to utilise their community knowledge and understanding when planning services, and to consult with community members through informal visits and discussions. This was also seen as beneficial as some AFHWs noted that formal consultations often lead to only certain voices being heard, whereas informal approaches through discussions with a range of community members ensures that a broader community perspective is taken into account. Many AFHWs noted that they had strong community connections and were community members themselves, which was important in enabling them to identify community needs.

> *"Around the women's group ... talking to them and they will come up with something ... The Elders too ... you sit around the Elders group, a lot of them talk about Elder's abuse in the group and they want workshops. 'What can we do for this Elder?' ... So it normally comes from the community ... and what they want and what they think we need to do." (AFHW)*

Along with receiving feedback during community engagement and through community networks, gaining feedback through other Aboriginal workers within community health services and community advisory groups was also identified. It was reported these were important sources of information as they are "on the ground" hearing and knowing what is going on in the community, and expands the potential reach of

input in understanding community needs across an often large and diverse local area. Another benefit of this approach was that drawing on existing knowledge and networks overcame difficulties in consulting community on a sensitive issue, and with the disillusionment of community with being over consulted. For these approaches that did not involve direct community consultation, going back to check with community and feeding back to community was a crucial part of the process.

> *"Aboriginal communities are consulted and consulted and consulted over and over and we hold some knowledge that's already been shared before with Aboriginal people and workers. So ensuring that we're capturing that voice from the community is to ensure that we've got people like [worker names] and some of the other positions around the table ... they bring that Aboriginal perspective and that community grass roots voice and if they're not sure about what that is then they can go back and check with who they need to; with Elders or groups or clients or whoever might be necessary to bring that story and that voice back. It might not be that direct consultation but quite often it is by that collective experience and knowledge that we already hold, and to keep with that check point in community." (AFH Coordinator)*

The level and method of community consultation and engagement varied. In some locations consultation was mainly focussed on involving community members that AFHWs were working with, and in other locations involvement extended to the community more broadly. While feedback indicated that community consultation had influenced service planning, some participants suggested that there could be additional avenues established for engaging broader community participation. For example, one suggestion for enhancing community engagement was to establish a community reference group.

## 7.2 AFHS initiatives reflecting local need and ownership

The ability of this evaluation to assess the extent to which AFHS initiatives reflect local needs and community ownership is limited given community members have not been included in this evaluation. However, AFHWs and AFH Coordinators feel the AFHS initiatives are generally meeting local needs, particularly those identified through the abovementioned consultation processes. This is further evidenced through the locally driven implementation of the AFHS itself, the range of diverse initiatives implemented across the communities, and the sense of local ownership promoted through the employment of local community members into AFHW roles.

Examples were provided of how AFHS initiatives responded to needs and community suggestions on program design and implementation. The ongoing process of consultation described above meant that as well as having input into initial ideas, in some cases community continued to input into development, delivery and refinement of initiatives, ensuring that implementation reflected the needs and design aspects community members had identified. In some instances this also led to community themselves taking ownership and progressing the activity further. For example, in one instance community feedback had led to specific community support groups being formed, such as men's groups, in others, community members provided input on the most appropriate support for issues experienced by members of the group.

> *"As a result of these programs, as well as consultation, they want to form some men's groups and establish some men's groups to address issues like these. So that's been such a positive*

*outcome in itself ... They're speaking with the relevant service to put something together." (AFH Coordinator)*

## 7.3 Building community knowledge, skills and capacity

The AFHS was felt to increase the knowledge, skills and capacity of Aboriginal communities to prevent and respond to family violence. AFHWs and AFH Coordinators pointed to a range of evidence supporting this including:

- Communities being more willing to speak up about family violence and its impact on the community
- Communities wanting to do something about family violence
- An increase in the profile of family violence and its seriousness
- Increased attendance at family violence education programs or other related sessions
- Greater engagement by men on the issue
- Increased understanding among victims (such as their rights, the court system etc).

Community education and community engagement were seen to be key facilitators in improving community knowledge, skills and capacity in relation to family violence.

> *"What I've seen around here is people are becoming more aware of it, it's coming more out in the open. It's not staying indoors, not staying in the house. People are coming out expressing their feelings and women and children, especially women, are coming out and getting help ... Even a lot of men are saying no to it, even the men are coming out trying to get help." (AFHW)*

It was also acknowledged that change was slow and requires long-term effort and input, particularly to continue to build on the increased knowledge and capacity seen among communities. Additionally, it was noted that the change seen was a result of a collaborative and community effort, not just due solely to the work of the AFHWs or AFH Coordinators themselves.

> *"I think the message is getting out more and more and it's getting to the male community. It's slow but the men's groups are talking about it. Some are still a bit scared about being branded perpetrators, or if they've been perpetrators in the past they don't feel like they can, but I think it's changing, slowly ... It's not just from us though ... it's got to be a group of people ... collaborative and community focused, and it's changing slowly. (AFHW)*

An area identified as requiring further work was recognising and identifying community leaders around the issue of family violence, which is outlined in the AFHS but was not felt to be a strong feature of implementation.

# 8. Summary of achievements, strengths and challenges

The following section presents a summary of activities and key evaluation findings on which the recommendations for consideration in the implementation of the AFHS into the future are based. The evaluation evidence presented in this report highlights the key strengths and challenges across the areas of effective service delivery, strategic leadership, culturally competent workforce and strong community capacity. These key achievements and challenges are summarised below.

Across the evaluation, feedback on the AFHS was consistently positive in relation to the overall effectiveness and appropriateness of the AFHS. The AFHS was felt to be culturally appropriate and relevant, due to its focus on family and local community needs, its acknowledgement of inter-generational trauma and the fact that it is delivered by Aboriginal workers.

> *"[The AFHS] should have been brought out years ago ... it is one of the only ones that specifically targets family as a family and ... it's that family orientated which Aboriginal culture's all about ... It talks about the past, present and future and the trauma ... and it brings it out in the open, what Aboriginal people have been going through and the direction they want to take now." (AFHW)*

## 1 IMPLEMENTATION AND EFFECTIVE SERVICE DELIVERY

| Achievements & strengths | Challenges |
|---|---|
| **AFHW and AFH Coordinator relationships** | |
| - Overall good working relationships among AFHWs and between AFHWs and AFH Coordinators in their region<br>- Statewide network meetings key source of connection between AFHWs<br>- Training courses and forums provided opportunities to connect with others<br>- Informal connections and networking between some AFHWs<br>- Collaborations between some AFHWs to coordinate events in their regions<br>- Sharing of resources and templates between AFHWs<br>- AFH Coordinators support each other within their roles and are in regular contact with one another through informal contact, bimonthly teleconferences and network meetings | - Opportunities for connection between AFHWs and AFH Coordinators has been limited to network meetings for some<br>- The statewide network meeting did not occur for over a year (prior to November 2014)<br>- For recently appointed AFHWs, the absence of the network meetings limited connections made with other AFHWs |
| **Local service delivery and coordination** | |
| - A wide range of activities have been conducted with considerable reach<br>- High numbers of self-referrals indicate a high level of engagement with the community by AFHWs<br>- The AFH Coordinator position has been implemented differently in each region, responding to regional | - The funding allocation was identified as limiting the reach of services and the initiatives that can be implemented, as well as contributing to challenges with recruitment. Participants also felt there was a need for an increased workforce to implement the AFHS.<br>- A lack of emergency crisis accommodation and |

| Achievements & strengths | Challenges |
| --- | --- |
| contexts<br>- Overall, AFHWs and AFH Coordinators work in a collaborative manner with other local services, and a broad range of partnerships, networks and stakeholder relationships have been developed<br>- There are good working relationships with other services and stakeholders<br>- AFHWs are members of interagency forums and working groups, with some establishing these groups themselves | alcohol and other drug rehabilitation services were cited as barriers to successfully delivering services that meet client needs<br>- A shortage of services and programs to support men and a shortage of male workers across services were identified as a significant challenge to responding to family violence in Aboriginal communities<br>- A lack of promotion of the AFHS has led to low levels of awareness of the AFHS in mainstream violence prevention initiatives and frameworks<br>- Staff turnover in other services was a challenge to relationship and partnership building<br>- Competition for limited funding was cited as a barrier to effective partnerships<br>- Difficulty working with some services or stakeholders who are protective / territorial over their client group |
| **Service delivery tools** | |
| - AFHW Operational Guidelines and the AFHS itself identified as being relevant and useful<br>- Guidelines provide flexibility to adapt approaches to particular communities or groups<br>- The AFHS document helped guide workers in their roles, as well as being used as an education tool to share with others<br>- The AFHS was used as a resource by some to develop further program design and implementation tools such as action / operational plans | - No central portal or space to access tools and resources |
| **Monitoring and evaluation**<br>- Program logic developed for the AFHS<br>- Periodic reporting form developed for AFHWs and AFH Coordinators to provide annual or biannual reports to NSW Health<br>- Some AFHWs have developed their own data collection methods to capture their activities / monitor data | - Minimal monitoring and accountability at a statewide level in the evaluation period<br>- Difficult to capture the extent of the work undertaken by AFHWs and AFH Coordinators, particularly the more qualitative components (e.g. community engagement, building partnerships with other services, stories of change among families and communities)<br>- Information provided in reports from AFHWs and AFH Coordinators is not easily aggregated to understand activities and reach across the AFHS as a whole<br>- Some activities and outputs for the AFHS described in the program logic not implemented |

# 2 STRATEGIC LEADERSHIP

| Achievements & strengths | Challenges |
| --- | --- |
| **The AFH Coordinator role** | |
| - Four AFH Coordinator positions in the Hunter New England, Mid North Coast, Northern NSW and Illawarra Shoalhaven LHDs<br>- AFH Coordinator positions are highly valued and seen to contribute significantly to the AFHS implementation<br>- AFH Coordinators well supported by their direct | - The high value placed on the work of the AFH Coordinators means there is significant concern that the position may not be re-funded<br>- Position uncertainty has also made forward planning challenging, and some felt limited in what they could achieve in a pilot position |

| Achievements & strengths | Challenges |
| --- | --- |
| managers<br>- AFH Coordinators have significantly contributed to building the capacity of the sector by coordinating training and supervision across the region<br>- Avenue for advice and support for their colleagues working with Aboriginal families<br>- As part of their role, AFH Coordinators have:<br>○ Provided cultural supervision and mentoring to Aboriginal and non-Aboriginal staff within the LHD<br>○ Coordinated supervision for colleagues<br>○ Developed or are in the process of developing a directory of services that provide health care and support to Aboriginal families<br>○ Developed networks or peer support groups (both formal and informal) with Aboriginal staff in LHD<br>○ Provided a link between AFHWs and broader LHD<br>○ Provided advocacy role through membership of LHD executives, management committees, meetings<br>○ Undertaken community development and engagement activities<br>○ Run awareness raising workshops and training | - Difficulties due to the role being a single person working across an LHD<br>- AFH Coordinators receive differing levels of support from senior management within their LHDs. This is reflected in the executives, committees and meetings they are included in and the commitment of these groups to engage with the issues raised by the AFH Coordinator<br>- Coordinating cultural supervision while not over-relying on the same individuals within services / communities<br>- Some community health staff or services do not recognise the need for cultural supervision<br>- Difficulties balancing the range of activities that make up the role and having the time to achieve everything |
| **Strategic partnerships** | |
| - Strategic partnerships developed at local and regional levels with a wide range of government agencies including FaCS, NSW Police, the NSW Ombudsman, Aboriginal Affairs, the Department of Education and Communities and ECAV<br>- Partnerships built with ACCHSs to facilitate better access to NSW Health services and resources<br>- Other partnerships built with local services in order to enhance cultural capacity of health workforce | - Varying levels of strategic partnerships have been developed across the LHDs<br>- Development of strategic partnerships were vulnerable to the challenges identified above in relation to the AFH Coordinator role<br>- The lack of promotion and visibility of the AFHS has likely impacted the development of partnerships at a strategic level<br>- Working with agencies and organisations that have a different approach, particularly those that operate in an environment that allows for limited flexibility was identified as a challenge at times |

# 3 CULTURALLY COMPETENT WORKFORCE

| Achievements & strengths | Challenges |
| --- | --- |
| **Knowledge, skills and capacity** | |
| - Overall, the skills, knowledge and capacity of AFHWs and AFH Coordinators increased while in their roles<br>- AFHWs and AFH Coordinators have accessed a range of relevant training and skills development opportunities<br>- The training opportunities provided to AFHWs and AFH Coordinators were seen as a key strength of the AFHS<br>- AFHWs who did not have Cert IV in Aboriginal Family Violence enrolled as part of their role<br>- The Advanced Diploma of Aboriginal Specialist Trauma Counselling was also undertaken by some and felt to be highly relevant and build capacity<br>- Knowledge and capacity development also led to | - Ongoing support and resources for staff to continue studies and further education and training<br>- Capacity building across the workforce in relation to cultural capacity is an ongoing process and requires significant time investment and ongoing commitment |

| Achievements & strengths | Challenges |
| --- | --- |
| personal changes in relation to values, attitude and increased personal confidence<br>- The reach of training and skills development went beyond AFHS staff themselves, with AFHWs and AFH Coordinators building capacity among others within their organisations and LHDs | |
| **Career pathways and development** | |
| - The experience and skills gained through the AFHS were seen to enhance career opportunities and pathways<br>- AFHWs and AFH Coordinators felt that their increased knowledge and skills would help their future employment prospects<br>- The AFH Coordinator position itself was seen to create pathways / career progression as it was a management level position | - Limited career pathways for Aboriginal health workers into senior positions, therefore the threat of losing AFH Coordinator positions was a key concern |
| **Supervision and support** | |
| - AFHWs generally felt well supported in their roles<br>- Having a combination / range of support mechanisms was a key contributor to feeling well supported<br>- Sources of support included the organisations (including team and managers), AFH Coordinators, ECAV, the Centre for Aboriginal Health, and belonging to Aboriginal health worker networks or groups<br>- Given the potential isolation of the AFHW positions, the role of the AFH Coordinators in providing supervision and support is an important element of the AFHS<br>- Cultural supervision provided by AFH Coordinator also valued for creating a safe space for Aboriginal workers to share | - Challenges with AFHWs feeling isolated because they are the only AFHW, and they deal with many issues they felt their co-workers could not understand<br>- Building connections, particularly where limited sources of support may exist, or if met with resistance |

# 4 STRONG COMMUNITY CAPACITY

| Achievements & strengths | Challenges |
| --- | --- |
| **Engagement to understand community needs** | |
| - Consultation to identify community needs was seen as an important approach to implementing the AFHS<br>- Consultation was largely through informal processes such as conversations with clients and community members to gain feedback and input<br>- Informal consultation processes also relied on the community networks and understanding of AFHS staff<br>- Feedback was also sought through Aboriginal workers within community health services and community advisory groups | - The level of community engagement varied where some locations mainly focussed on involving clients while others involved the community more broadly<br>- While feedback indicated that community consultation had influenced service planning, some participants suggested that there could be broader community participation |
| **Initiatives reflecting local need and ownership** | |
| - AFHWs and AFH Coordinators feel AFHS initiatives meet local needs identified by community | - The extent to which this evaluation can assess whether AFHS initiatives reflect local needs and led to |

| Achievements & strengths | Challenges |
| --- | --- |
| consultation<br>- Ongoing consultation processes in some locations meant that as well as having input into initial ideas, community continued to input into development, delivery and refinement of initiatives<br>- Examples were given where community members had taken ownership of specific activities they had designed | community ownership is limited given community members have not been included in the evaluation |
| **Building community knowledge, skills and capacity** | |
| - The AFHS was felt to increase the knowledge, skills and capacity of Aboriginal communities to prevent and respond to family violence<br>- Examples were given of communities being more willing to speak about family violence, communities wanting to do something about family violence, raising the profile of family violence, increased attendance at family violence education programs, greater engagement by men on the issue, and increased understanding among victims<br>- Community education and engagement were seen to be key facilitators in improving community capacity | - Given the sensitivity and complexity of the issue community change will be slow and require long-term effort and input<br>- Attributing community change to the AFHS is difficult as the changes seen are a result of collaborative and community efforts, of which the AFHS is a part<br>- It was identified that more could be done to recognise and identify community leaders for family violence, which is outlined in the AFHS but was not felt to be a strong feature of implementation |

# 9. Conclusions & recommendations for consideration

The evaluation found that the Aboriginal Family Health Strategy, specifically the two key components of the AFHW and AFH Coordinator roles, were considered by stakeholders to be effective and appropriate. The activities and outputs delivered by the AFHS have been locally driven and varied across communities and LHDs. AFHWs, AFH Coordinators, managers and chief executives of ACCHSs felt that the AFHS is a valid and purposeful way of delivering services and the evaluation indicates that the AFHS has reached the intended client groups.

A key limitation for the current evaluation is that qualitative feedback was limited to those involved in implementing the AFHS. Future monitoring and evaluation could enable feedback from community members and other stakeholders in order to better understand the reach and impact of the Strategy from these perspectives.

The following recommendations are offered for consideration in the implementation of the AFHS into the future across the areas of effective service delivery, strategic leadership, culturally competent workforce and strong community capacity.

## 9.1 Recommendations for consideration

### 1 IMPLEMENTATION AND EFFECTIVE SERVICE DELIVERY

1. Continue to strengthen the AFHS including AFH Coordinator positions
2. Consider the following challenges in future planning:
    - Program funding for AFHS activities implemented by AFHWs and AFH Coordinators
    - Recruitment and retention of staff, particularly in remote and challenging locations
3. Ensure network meetings are held regularly and improve induction processes to better support new workers and facilitate connections between AFHS positions
4. Facilitate connections between AFHS positions and other relevant partners and stakeholders, including ACCHSs, relevant LHD staff and government agencies
5. Maintain flexibility in AFHS approach so that AFHW and AFH Coordinator roles can continue to be responsive to local needs and contexts
6. Facilitate greater sharing of resources and tools (e.g. a central website or portal and a private social networking page for AFHWs and AFH Coordinators)
7. Refine program monitoring in consultation with AFHWs and AFH Coordinators. This should include:
    - Updating data collection systems to record program activity and also capture qualitative and narrative data more effectively
    - Developing a template or platform for AFHWs and AFH Coordinators to support ongoing monitoring data collection, with the capacity for this to output periodic reports required by NSW Health and enable aggregation across the AFHS
    - Reinstating and refining ongoing monitoring systems, including providing feedback on submitted reports

## 2 STRATEGIC LEADERSHIP

8. Consider strategies to better integrate the AFH Coordinator role into existing relevant LHD structures e.g. inclusion on executive and management committees
9. Undertake greater promotion of the AFHS to facilitate the development of strategic partnerships and visibility in mainstream violence prevention initiatives and frameworks

## 3 CULTURALLY COMPETENT WORKFORCE

10. Continue to support AFHWs to undertake the Certificate IV in Aboriginal Family Health (Family Violence, Sexual Assault & Child Protection) and further relevant education, in particular the Advanced Diploma in Aboriginal Specialist Trauma Counselling
11. Identify additional opportunities to support skills and capacity development, such as traineeships for AFHWs

## 4 STRONG COMMUNITY CAPACITY

12. Continue resourcing the Education Centre Against Violence to deliver community education around family violence and family health
13. Investigate strategies to support AFHWs and AFH Coordinators to extend community engagement and participation
14. In planning future evaluations of the AFHS, investigate ways to obtain feedback from community members in order to further assess the effectiveness of the AFHS in building community knowledge, capacity and ownership, and responding to local needs

# References


Aboriginal Child Sexual Assault Taskforce, 2006. *Breaking the Silence: Creating the Future - Addressing child sexual assault in Aboriginal communities in NSW,* 2006: NSW Attorney General's Department.

ANROWS, 2014. *Fast Facts on Indigenous family violence,* s.l.: Australia's National Research Organisation for Women's Safety Limited (ANROWS), accessed 12 November 2015, <http://www.anrows.org.au/sites/default/files/Fast-Facts–Indigenous-family-violence_0.pdf>.

Australian Institute of Health and Welfare, 2014. *Indigenous Child Safety,* Canberra: AIHW Cat. no. IHW 127, accessed 2 February 2015 <http://www.lawlink.nsw.gov.au/lawlink/acsat/acsat.nsf/vwFiles/80001%20CP%20Rep-all_sml.pdf/$file/80001%20CP%20Rep-all_sml.pdf>.

Education Centre Against Violence, n.d. *Aboriginal Programs,* accessed 18 December 2014, <http://www.ecav.health.nsw.gov.au/uploads/60438/ufiles/pdf/Courses_and_Publications_Section_B_Aboriginal_Program_Area.pdf>: NSW Health.

NSW Bureau of Crime Statistics and Research, 2010. *NSW Health data request on number of Indigenous victims of domestic violence related assault recorded by the NSW Police, NSW Recorded Crime Statistics from July 2006 to June 2009,* Sydney: NSW Department of Justice.

NSW Department of Health , 2011. *Aboriginal Family Health Strategy 2011-2016: Responding to family violence in Aboriginal communities ,* Sydney : NSW Department of Health .

NSW Department of Health, 2008. *Operational Guidelines for Aboriginal Family Health Workers,* http://www0.health.nsw.gov.au/policies/gl/2009/GL2009_001.html: NSW Department of Health.

NSW Department of Health, 2010. *Mortality and Hospitalisation due to Injury in the Aboriginal Population of New South Wales,* Sydney: NSW Department of Health .

NSW Department of Health, 2011. *Aboriginal Family Health Strategy 2011-2016: Responding to Family Violence in Aboriginal Communities,* Sydney: NSW Department of Health.

NSW Department of Premier and Cabinet, 2009. *Keep Them Safe: A shared approach to child wellbeing,* Sydney : NSW Government .

NSW Government, 2013. *OCHRE: NSW Government Plan for Aboriginal affairs: education, employment and accountability,* Sydney: NSW Government, <http://www.aboriginalaffairs.nsw.gov.au/wp-content/uploads/2013/04/AA_OCHRE_final.pdf>.

NSW Government, 2014. *It Stops Here: Standing together to end domestic and family violence in NSW,* Sydney: NSW Government, <https://www.women.nsw.gov.au/__data/assets/file/0003/289461/It_stops_Here_final_Feb2014.pdf>.

NSW Health, 2012. *NSW Aboriginal Health Plan 2013-2023,* Sydney: NSW Ministry of Health, <http://www.health.nsw.gov.au/aboriginal/Documents/aboriginal-health-plan-2013-2023.pdf>.

NSW Kids and Families, 2014. *Healthy, Safe and Well: A strategic health plan for children young people and families 2014-24,* Sydney: NSW Kids and Families, <http://www.kidsfamilies.health.nsw.gov.au/media/233616/strategic-health-plan-final-low-res.pdf>.

# Appendix 1 – Interview guide

## Aboriginal Family Health Workers and Aboriginal Family Health Co-ordinators

### Introduction

I am from the Cultural and Indigenous Research Centre Australia (CIRCA) and we have been engaged by the NSW Ministry of Health to conduct an evaluation of the NSW Aboriginal Family Health Strategy. As part of the evaluation, we are speaking to Aboriginal Family Health Workers, Aboriginal Family Health Coordinators and key stakeholders to get feedback on the program and people's experiences.

Explain:

- The feedback you provide is confidential - we don't record any of your personal details so anything you say will not be linked to you, you will remain anonymous - only the evaluators (i.e. the CIRCA team) will have access to information about participants.
- We would like to record the interview on a digital recorder. The recording is just for the research team to help us with our notes so that our report includes all your thoughts/ideas. Are you happy for us to record the group?
- Participation in the interview / discussion group is voluntary, and you can choose not to participate in part or all of the discussion.
- If you don't want to or can't answer any questions, you don't need to worry about it, we will just move on. This is an open discussion and all comments are welcome – there are no right or wrong answers.

The interview / discussion will take about 1 to 1.5 hours.

Do you have any questions before we begin? *(If Yes, answer questions)*

**Consent:**

Do you agree to participate in the interview? Yes/No

Are you happy for the interview to be recorded? Yes/No		If no I will take notes.

## General / introduction

1. How long have you been an AFHW / Co-ordinator? Can you tell me a little bit about your role?
2. What is an average day / week at work like for you?

## Service delivery

**For AFHWs**

3. Have you had a specific area of focus for your position? If so, what has that been?
4. What sorts of things have been put in place in your local area to address family violence in Aboriginal communities? (exploring existing initiatives / services beyond the AFHW role)
5. What sort of things have you done in your role? How did you do that? [If not mentioned prompt for workshops, forums, support groups, programs, family support / crisis intervention, community education]
6. What has worked well? [Prompt for key strengths]
7. What hasn't worked so well? [Prompt for any weaknesses]

**For Co-ordinators:**

8. What different models and approaches have been applied in your region?
9. What has worked well?
10. What hasn't worked so well?
11. What have been the key strengths of these approaches?
12. What about any weaknesses?

**For AFHWs and Co-ordinators:**

13. How are potential clients for Aboriginal family health services identified in your local area / region (region for Co-ordinators)? How do you keep clients on board / engaged in programs/services?
14. How well do you think services / initiatives in your local area (region for Co-ordinators) are reaching those most in need?
15. How do you think the reach of existing and new projects could be improved?

## The Aboriginal Family Health Co-ordinator role / relationships

**For AFHWs:**

16. Is there an Aboriginal Family Health Co-ordinator in your area? If yes:

    - Has the introduction of the Co-ordinator role made a difference to your role / implementation of the Aboriginal Family Health Strategy in your area / local health district (LHD)? How?
    - How has the Co-ordinator supported you in your role? [Prompt for: enabled linkages with the health system and other programs / organisations, helped develop partnerships] How has this gone?

17. Have you developed relationships with other AFHWs / Co-ordinators? How did those relationships develop? How has that worked?

**For Co-ordinators:**

18. How do you see the role of the Co-ordinator? How do you feel the role has gone for you? Why?
19. [Where relevant] Has the introduction of the Co-ordinator role made a difference to the implementation of the Aboriginal Family Health Strategy in your area / local health district (LHD)? How?
20. How have you worked with the AFHWs in your area? How has this gone?
21. Have you developed relationships with other AFHWs / Co-ordinators? How did those relationships develop? How has that worked?
22. What regional and state linkages currently exist for Aboriginal family health service delivery?

## Partnerships, linkages, collaborations

23. How do Aboriginal family health / family violence service providers work together in your local area / region? (e.g. Aboriginal Community Controlled Health Services, Local Health Districts, Medicare Locals, etc)? i.e. What partnerships / collaborations / relationships exist?

    - How have these relationships developed?
    - What has / hasn't worked? Why?

24. What about at a state or regional level - have relationships developed or links been established to help deliver services to address family violence in Aboriginal communities?

- How did this come about?
- What has / hasn't worked? Why?
- If not mentioned, how about working with NSW Health and other state level stakeholders - have you engaged with them in your role? How?

25. What are the facilitators / barriers to establishing partnerships / working with others to address family violence in Aboriginal communities?
26. How do you think services / key stakeholders in your local area / region could work better together? i.e. How can partnerships / relationships be broadened and strengthened?
27. What do you think about the overall leadership / coordination of the Aboriginal Family Health Strategy? What about at a state level?
28. Is there anything you would change to improve overall leadership / coordination / support to help address family violence in Aboriginal communities in your area / region?

## Service delivery tools

29. Are you aware of any service delivery tools that have been developed to guide and monitor Aboriginal family health initiatives (e.g. guidelines, policies, protocols, strategies)?
30. Do you use any of these tools? If so, how?
31. What would you change to improve current service delivery tools?

## Professional development and culturally competent workforce

**NOTE: Questions 32-36 to be covered in a separate one-on-one discussion with AFHWs at the end of the interview if interview conducted in a group**

32. What knowledge and skills (relevant to Aboriginal family health) have you developed in your role?
33. Have you undertaken any training as part of your role? If so, what was it? Was it helpful?
34. How do you think your role as an AFHW would help you with future employment? (i.e. has affected your future career prospects)
35. Where do you see yourself in terms of work / career (professionally) in 5 years?

36. How supported do you feel in your role?
    - How is cultural safety supported in your workplace?
    - What do you do to support others?
    - How do you think cultural safety and support within NSW Health could be improved?
37. What is your impression of the cross-cultural knowledge, skills, awareness and attitudes of other services that deliver services/programs to address family violence in Aboriginal communities in your local area / region?
38. Do you know of anything that has been done to help support the cross-cultural knowledge, skills, awareness and attitudes of other services that deliver services/programs to address family violence in Aboriginal communities in your local area / region? Explore
39. How do you think the cultural competence of the sector (i.e. service providers delivering programs and services to address family violence in Aboriginal communities) could be improved?

## Strong community capacity

40. Who leads / takes ownership of the Aboriginal family health projects implemented in your area?
41. How do you feel these projects addressed community needs? [Prompt to understand how needs were identified and addressed]
42. What changes in knowledge and skills in relation to family violence in Aboriginal communities have you observed at a community level in your local area?
43. How would you improve community capacity in Aboriginal family health in your local area?
44. How have Aboriginal communities in your local area been engaged in service planning / development / delivery?
45. In terms of the Aboriginal Family Health Strategy, what do you see as the overall successes and challenges for developing strong community capacity?

## Final reflections

46. The purpose of the Aboriginal Family Health Strategy is to reduce the incidence of family violence in Aboriginal communities...

- What is your overall impression of its relevance and appropriateness?
- Does the model need to change?
- What is your overall impression of its impact and whether it has made a difference?

47. Are you aware of any other documents or evaluation reports that have been developed locally that might be relevant to the Aboriginal Family Health Strategy and that you may be able to/are happy to provide us to consider as part of the evaluation?

### Thank and close

# Appendix 2 – Program Logic

## Program Logic

### Inputs

**Direct inputs:**

**Aboriginal Family Health Strategy:**

- Aboriginal Family Health Workers (AFHW)
- Aboriginal Family Health Coordinators

**Training and education:**

Training delivered by the Education Centre Against Violence (ECAV).

**In-direct inputs:**

**Broader system response:**

- Mainstream service provision
- Aboriginal Community Controlled Sector
- Other Non-Government Organisation (NGO) service provision.
- Specialised family violence services.
- Workforce investment
- Education and training.
- Interagency collaboration

**Existing support:**

The strength and resilience of Aboriginal families and communities and the good will and commitment of those working in the area of family violence in Aboriginal communities.

### Strategies → Activities & Outputs

**Strategic leadership**

- Develop Aboriginal Family Health Service Guidelines.
- Trial Aboriginal Family Health Coordinator positions in three Local Health Districts (LHD).
- Aboriginal Family Health lead person identified in each LHD
- Establish Aboriginal Family Health Implementation Committee.
- Develop Aboriginal Family Health Strategy Communication protocols.
- Develop effective strategic partnerships with key stakeholders.

**Effective Service Delivery**

- Aboriginal Family Health Plans developed and implemented.
- Aboriginal Family Health Action Groups established to support implementation of the Strategy.
- Service partnerships developed at both local and regional level.
- Aboriginal Health Impact Statement and Aboriginal Family Health Service Guidelines to be used as ongoing service delivery tools.
- Recruitment and training of new Aboriginal Family Health Workers.
- Aboriginal Family Health Worker Operational Guidelines redeveloped and implemented.

**Culturally competent work force**

- Support the delivery of cultural competency training and resources, including Competent Responses to Aboriginal Sexual Family Violence, to health service staff that work with Aboriginal families.
- Support Aboriginal Health Workers to undertake the Certificate IV Aboriginal Family Violence, the Advanced Diploma in Aboriginal Trauma Counselling and related training.
- Establish Aboriginal Family Health Worker Traineeship Program.
- Incorporate the Aboriginal Family Health Program into the NSW Health Aboriginal Workforce Development Strategy.

**Strong community capacity**

- Engage and empower local Aboriginal communities in all aspects of service planning, development and delivery of solutions for family violence services.
- Support the delivery of community based education and awareness programs by Aboriginal Family Health Program and related services, including those of ECAV.
- Utilise Regional Family Health Action Groups to share information and keep AFHWs and health services informed of relevant education, awareness and prevention activities in family violence.

# Activities and outputs described in the program logic

The following table outlines the implementation status of the activities and outputs as described in the program logic.

**Table 6: Implementation status of activities and outputs listed in program logic**

| Activities and outputs | Implementation status<br>✓ Yes, ✗ No, ○ In part | Additional notes |
|---|---|---|
| **Strategic leadership** | | |
| Develop Aboriginal Family Health Service Guidelines | ✗ | |
| Trial Aboriginal Family Health Co-ordinator Positions in three Local Health Districts | ✓ | Positions trialled in Hunter New England, Illawarra Shoalhaven, Mid North Coast and Northern NSW LHDs |
| Aboriginal Family Health lead person identified in each LHD | ✗ | |
| Establish Aboriginal Family Health Implementation Committee | ✗ | |
| Develop Aboriginal Family Health Strategy Communication protocols | ✗ | |
| Develop effective strategic partnerships with key stakeholders | ✓ | |
| **Effective service delivery** | | |
| Aboriginal Family Health Plans developed and implemented | ○ | Some AFH Coordinators have developed plans for their LHDs, but unclear whether these have been implemented |
| Aboriginal Family Health Actions Groups established to support implementation of the Strategy | ○ | Regional network established in one LHD |
| Service partnerships developed at both local and regional level | ✓ | |
| Aboriginal Health Impact Statement and Aboriginal Family Health Service Guidelines to be used as ongoing service delivery tools | ✗ | |
| Recruitment and training of new Aboriginal Family Health Workers | N/A | No new AFHW positions established since 2009 |
| Aboriginal Family Health Worker Operational Guidelines redeveloped and implemented | ○ | Existing Operational Guidelines implemented (published February 2009) but not redeveloped |
| **Culturally competent workforce** | | |
| Support the delivery of cultural competency training and resources, including Competent Responses to Aboriginal Sexual Family Violence, to health service staff that work with Aboriginal families | ✓ | |
| Support Aboriginal Health Workers to undertake the Certificate IV Aboriginal Family Violence, the Advanced Diploma in Aboriginal Trauma Counselling and related training | ○ | AFHWs have been supported to undertake the Certificate IV, but there is scope for more AFHWs to be supported to undertake the Advanced Diploma |

| Establish Aboriginal Family Health Worker Traineeship Program | ✘ | |
|---|---|---|
| Incorporate the Aboriginal Family Health Program into the NSW Health Aboriginal Workforce Development Strategy | ✔ | Included in Aboriginal Health Worker Guidelines for NSW Health (2014) |
| **Strong community capacity** | | |
| Engage and empower local Aboriginal communities in all aspects of service planning, development, and delivery of solutions for family violence services | ○ | Ongoing process – varied across locations and services. Limited capacity for the evaluation to assess |
| Support the delivery of community based education and awareness programs by Aboriginal Family Health Program and related services, including those of ECAV | ✔ | |
| Utilise Regional Family Health Action groups to share information and keep AFHWs and health services informed of relevant education, awareness and prevention activities in family violence | ✘ | |

# Appendix 3 – AFHW data collection form

| NSW Aboriginal Family Health Worker Data Collection | | | |
|---|---|---|---|
| **Refer to Explanatory Notes (p5) for information on how to complete each part.** | | | |
| **Part I – Service information** | | | |
| Name of service | | Date __ __/ __ __/20 __ __ | |
| Name of person completing this form | | Position | |
| Contact phone number | | Email | |
| Reporting period | ☐ Half year (July to December) | (Report due February) | Year 20 __ __ |
| | ☐ Full year (July to June) | (Report due August) | Year 20 __ __/ 20 __ __ |
| Is the position of Aboriginal Family Health Worker currently filled? | ☐ Yes | Is the position filled by an Aboriginal person? ☐ Yes ☐ No | |
| | ☐ No | How long has the position been vacant? __ __ months | |
| Name of Aboriginal Family Health Worker | | Date commenced at this service __ __/ __ __/ 20 __ __ | Hours per week |

| Part II - Service delivery | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A Aim: Provide prevention and early intervention programs and activities | | | | | | | | | |
| **1. Name of activity/ program** | **Dates** | **No. of sessions** | **Topic** | **Partner agencies** | **Role of AFHW** | **No. of participants** | **Target audience** | **Plans** | **Outcome** |
| a. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| b. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| c. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| d. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| **General comments** | | | | | | | | | |

| B | Aim: Develop awareness of and provide education on family violence in the community | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **2. Activity** | **Dates** | **No. of sessions** | **Topic** | **Partner agencies** | **Role of AFHW** | **Number of participants** | **Target audience** | **Plans** | **Outcome** |
| a. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| b. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| c. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| **General comments** | | | | | | | | | |

B Aim: Develop awareness of and provide education on family violence in the community

| 2. Activity | Dates | No. of sessions | Topic | Partner agencies | Role of AFHW | Number of participants | Target audience | Plans | Outcome |
|---|---|---|---|---|---|---|---|---|---|
| a. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| b. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| c. | | | | | | | | | |
| | **Aim** | | | | | | | | |
| | **Results** | | | | | | | | |
| **General comments** | | | | | | | | | |

| C | Aim: Provide services to victims and their families | | | | | | | **Outcome** |
|---|---|---|---|---|---|---|---|---|
| **3. Crisis and ongoing intervention and support** | **a. Number of clients seen in reporting period** | _____ females (16 years and over) | | | _____ males (16 years and over) | | | |
| | | _____ children (0 – 15 years) | | | _____ total number of **clients** seen | | | |
| | | _____ total number of **visits** | | | | | | |
| | **b. Main issues** | What are the main issues that clients present with/are referred for? Please indicate for the following the level of priority you need to allocate in your role as an AFHW - High **(H)** Medium **(M)** Low **(L)** | | | | | | |
| | | domestic violence | __ | abuse/neglect of children | _ _ | drug and alcohol issues | _ _ | |
| | | sexual assault | __ | abuse/neglect of older persons | _ _ | mental health issues | _ _ | |
| | | child sexual assault | __ | housing | _ _ | Other | _ _ | |
| | **c. % of workload spent on services for victims and their families** | Estimated percentage of the Aboriginal Family Health Worker workload spent with victims and their families and related work. This includes direct contact with clients plus other time for related activities (such as making referrals, meetings about client). _____ % of total workload | | | | | | |

| **4. Referrals** | **a. Referrals received** | Number by source | _____ | Self-referrals | _____ | NSW Health services | |
|---|---|---|---|---|---|---|---|
| | | | _____ | Community Services | _____ | Housing | |
| | | | _____ | GP | _____ | Police | |
| | | | _____ | Other. Specify. _____ | | | |
| | **b. Referrals made** | Number by where referred to | _____ | NSW Health drug and alcohol service | _____ | Centrelink | |
| | | | _____ | NSW Health mental health service | _____ | Housing | |
| | | | _____ | NSW Health sexual assault services | _____ | Crisis accommodation | |
| | | | _____ | NSW Health Child Wellbeing Unit | _____ | Aged Care Assessment Team (ACAT) | |
| | | | _____ | NSW Health Family Referral Service | _____ | GP | |
| | | | _____ | NSW Health service (other) | _____ | Community Services | |
| | | | _____ | Other | | | |
| | **c. Child protection contacts** | Number of contacts made | | Community Services Child Protection Helpline | | _____ | |
| | | | | Health Child Wellbeing Units | | _____ | |
| | | | | Family Referral Services | | _____ | |
| | **d. Referral issues** | Describe referral issues which have caused difficulty | | a. Name of service _____ b. Name of service _____<br>Referral difficulty ___________ Issues with referrals _____ | | | |
| **5. Advocacy on behalf of clients** | **Representations** | Number by organisation | _____ | Local court (AVO) | _____ | Centrelink | |
| | | | _____ | Accommodation organisations | | | |

| Part III - Management | | | | |
|---|---|---|---|---|
| D Aim: Provide an efficient service which meets the priority needs of clients | | | | |
| **6. Prepare funding submissions** | **Submissions** | a. Name of submission _____<br>Organisation _____<br>Successful?_ ☐ Yes ☐ No<br>b. Name of submission _____<br>Organisation _____<br>Successful? ☐ Yes ☐ No | | |
| Aim: Support ongoing professional development | | | | |
| **7. Orientation program** | Orientation program | Orientation program provided to the AFHW within the first month of employment? | ☐ Yes ☐ No. Reason _____ | |

| 8.Professional supervision | Supervision sessions | Number of supervision sessions | _____ number of supervision sessions |
|---|---|---|---|
| | | Provision of supervision | Who has provided this supervision? (position) _____ |
| 9. Debriefing sessions | Debriefing | Number of debriefing sessions | _____ number of debriefing sessions |
| 10. Cert IV | ECAV Cert IV | Cert IV status | ☐ Completed ☐ In progress ☐ Not started |
| 11. Continuing education | Other training | Details of other training attended | Name of training __________ Duration _____ |
| 12. AFHW network meetings | Attended AFHW meetings | Number of Aboriginal Family Health Worker meetings attended | ☐ Attended all AFHW meetings in reporting period<br>☐ Attended one meeting in full year<br>☐ Did not attend any meetings in reporting period |

## Part IV - Co-ordination and linkages

F Aim: Establish links with government and non-government organisations to facilitate improved service provision

| 13. Establish collaborative networks with external organisations that support the Aboriginal Family Health Strategy | External networks | Name of network | Key focus | Key partners | Number of meetings |
|---|---|---|---|---|---|
| | | _____ | _____ | _____ | _____ |
| | | _____ | _____ | _____ | _____ |
| | | _____ | _____ | _____ | _____ |
| 14. Overall comments | | | | | |

# Appendix 4 – AFH Coordinator evaluation form

| **Aboriginal Family Health Coordinator Information** | | | |
|---|---|---|---|
| Name of person completing this form: | | Position: | |
| Contact Email: | | Contact Phone: | |
| Reporting Period: | ☐ Half Year | *(Report due March)* | Year 20_ _ |
| | ☐ Full Year | *(Report due September)* | Year 20_ _ / 20 _ _ |
| Is the position of Aboriginal Family Health Coordinator currently filled | ☐ Yes | Is the position filled by an Aboriginal person? | ☐ Yes |
| | ☐ No | | ☐ No |
| Name of Coordinator: | | If not filled, how long has the position been vacant | __ years |
| LHD: | | | __ months |

| **Health Coordination Information** |
|---|
| **Strategic Leadership** |
| 1. Develop a Regional Aboriginal Family Health Action Plan to facilitate the implementation of the Aboriginal Family Health Strategy within a local context. |
| *Was a plan developed? When was it released, who was signatory to it, and has it been reported on? Provide a copy of the Plan.* |
| *Response:* |
| |
| 2. Work with existing Network Violence Prevention Coordinators or coordinate a Local Health Network *Aboriginal Family Violence Advisory Committee* to provide leadership guidance for the implementation of the Aboriginal Family Health Coordinator role. |
| *Was an 'Aboriginal Family Violence Advisory Committee' convened? Identify members and provide information on activity (eg Terms of Reference, meeting minutes).*<br>*If a Committee was not convened provide evidence of activity with other Violence Prevention Coordinators or similar partners.* |
| *Response:* |

| |
|---|
| |
| 3. Attend and participate as an active member on family violence prevention committees and related forums at a local, state and national levels, including:<br>• Area Violence Prevention Executive — Area Domestic Violence Committee<br>• Aboriginal Health Workers Forum — Aboriginal Family Health Workers Network meeting<br>• AMIHS Area Program meetings — Area Child Protection Coordination Committee |
| *List the committees, forums and meetings attended and show examples of active participation.* |
| *Response:* |
| |
| 4. Provide policy and program advice as required on matters relating to family violence in Aboriginal communities. |
| *Identify policies and programs for which advice was provided.* |
| *Response:* |
| |
| 5. Maintain links with equivalent Coordinator positions in other trial sites. |
| *Did the Coordinator meet with or communicate with other Coordinators regularly? Describe contact.* |
| *Response:* |
| |
| 6. Maintain proper documentation, monitor and provide quality reports and correspondence on regional community strategies and activities to inform the ongoing implementation of the Aboriginal Family Health Strategy. |
| *Identify examples of relevant documentation and reports and provide copies if available.* |
| *Response:* |
| |
| 7. Contribute to the development, implementation and evaluation of related women's health plans (eg women's health, youth health) |
| *How has the Coordinator contributed to related health plans? Identify these plans.* |
| *Response:* |
| |

| *Effective Service Delivery* |
|---|
| 8. *Identify, establish and maintain effective partnerships and working relationships with key Health local stakeholders and family violence service providers within both mainstream, and Aboriginal services and communities.* |
| *Identify formal partnerships and provide evidence such as MOUs or signed agreements. Identify working relationships and evidence of these such as documented referral processes.* |
| *Response:* |
| |
| 9. *Assist in the development and implementation of service improvement initiatives that address family violence issues in local communities.* |
| *Describe service improvement initiatives and provide examples of outcomes/intended outcomes.* |
| *Response:* |
| |
| 10. *Build and document evidence base for local need and work in partnership to develop appropriate responses.* |
| *Describe needs assessment process and documented evidence. Describe activity initiated in response to needs assessment.* |
| *Response:* |
| |
| 11. *Compile a directory of key local and regional stakeholders that can support an Aboriginal Family Health response.* |
| *Was a directory developed? If so describe its contents.* |
| *Response:* |
| |
| 12. *Map services to increase access and choice of services for clients.* |
| *If undertaken provide examples and describe how access to and/or choice of services was increased.* |
| *Response:* |

| |
|---|
| 13. *Collaborate with related violence prevention programs (eg. Keep Them Safe) to contribute to the implementation of the key NSW and local health policy.* |
| *What other programs did the Coordinator contribute to? Provide examples.* |
| *Response:* |
| |
| *Culturally Competent Workforce* |
| *14. Consistent with the NSW Health Cultural Respect Framework, support implementation of the relevant Cultural Awareness Program for the Network.* |
| *In what way has the implementation of Cultural Awareness programs within the Network been supported?*<br>*Provide information (name of program, venue, numbers attending, partners) on specific programs where possible.* |
| *Response:* |
| |
| 15. *Contribute to ensuring a culturally safe workplace for Aboriginal and Torres Strait Islander staff, partners and clients.* |
| *Provide evidence of efforts to ensure a culturally safe workplace and partners involved in this process eg appropriate meeting rooms/office space, identification of Aboriginal clients.* |
| *Response:* |
| |
| 16. *Support the development of Network learning resources and training packages on family violence.* |
| *Identify resources and training packages and describe involvement of the Coordinator.* |
| *Response:* |
| |
| 17. *Support the implementation of staff learning and development strategies in relation to family violence.* |
| *Has such a strategy been developed?* |

| *What training have staff participated in?* |
|---|
| *Response:* |
| |
| 18. *Promote a holistic and integrated approach across government services, service sectors and communities, particularly identifying opportunities for program linkages.* |
| *Give examples of program linkage developed or supported by the Coordinator, describing how this supported a holistic approach.* |
| *Response:* |
| |

| **Strong Community Capacity** |
|---|
| 19. Promote a focus on healing, prevention, community development and early intervention in conjunction with Aboriginal Family Health Workers (AFHWs) and key Local Health Network stakeholders within available resources. |
| *Identify relevant activity and provide program information (objectives, activities, venue, numbers, partners). Identify the community, AFHWs and other stakeholders involved.* |
| *Response:* |
| |
| 20. Assisting to build capacity with Aboriginal Community Controlled Health Services and other key partners to enhance service provision and information sharing through the development of formalised partnerships and referral pathways |
| *Describe partnerships and referral pathways and identifying partners and participants in the Aboriginal Community sector.* |
| *Response:* |
| |
| 21. Advocate for shared responsibility of outcomes, by involving the Aboriginal community and LHN in decision-making. |
| *Provide examples of projects undertaken in partnership with the Aboriginal community.* |
| *Response:* |
| |

| 22. Advocate for additional resources for family violence response activities. |
| --- |
| *Did the Coordinator contribute to the provision of additional resources that were directed to areas of family violence? Specify.* |
| *Response:* |
| |
| 23. Assist with showcasing successful projects to other communities. |
| *How have successful projects been showcased? Identify projects and the way they were publicised/promoted. Advise if this led to others initiating similar projects.* |
| *Response:* |
| 24. Identify gaps in service provision (within communities) and advocate for resources to meet these needs. |
| *How were gaps identified within communities?  Describe response including advocacy for resources if undertaken.* |
| *Response:* |

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