the Lowitja INSTITUTE

Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

Workforce Roundtable

Notes

Thursday, 15 September 2011

10:00am – 4:00pm

Chifley Hotel at Lennons

Brisbane, Queensland

Australia

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Welcome to Country

Auntie Carol Currie

Auntie Carol is a Pooneeba and Mununjali Elder from South-east Queensland. She was born in Fingal and now resides in Brisbane.

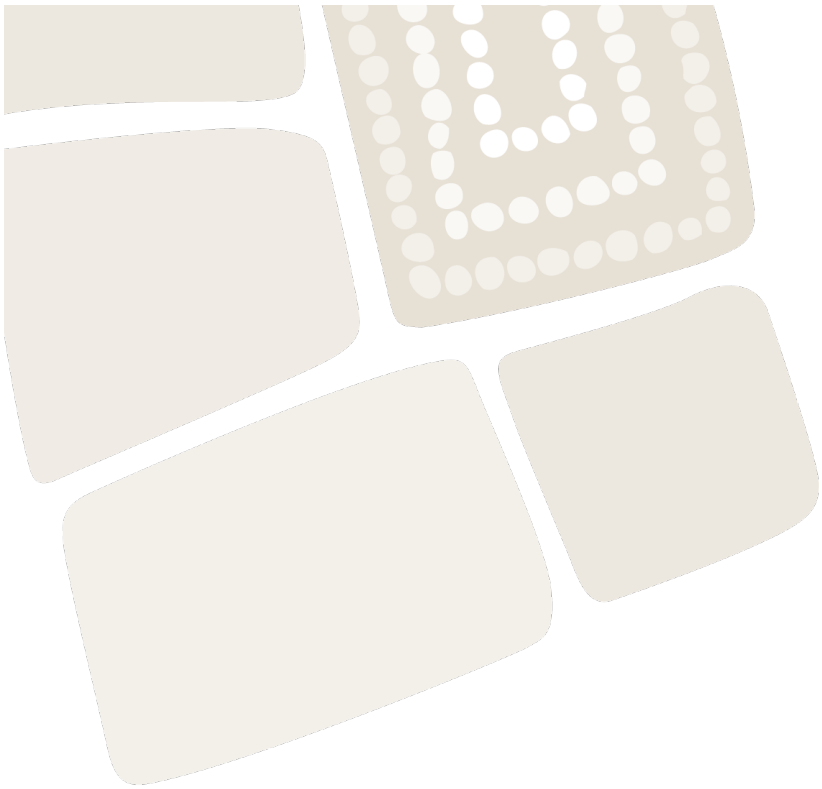
Facilitator

Ms Leilani Pearce

Presenters

Professor Cindy Shannon	Director, Centre for Indigenous Health; Pro Vice Chancellor, The University of Queensland
Mr Romlie Mokak	Chief Executive Officer, Australian Indigenous Doctors Association
Mr Tom Brideson	Statewide Coordinator, NSW Aboriginal Mental Health Workforce Program
Mr Alwin Chong	Program Leader, The Lowitja Institute
Professor Judith Dwyer	Program Leader, The Lowitja Institute

A full list of participants is available in Appendix 2, p.43.



Workshop Aims

An overview of the expectations from the Roundtable

Professor Judith Dwyer

Judith outlined the purpose of the Roundtable, which is to gather ideas and knowledge from the participants that will enable the Institute to commission one or two workforce research projects that address high priority areas. We hope that at the end of the day we will have a few clear proposals for areas of research focus that we can take away and develop further. Ultimately, we will commission research teams to conduct projects based on the thinking from today, and we aim to commence the commissioning process with a call for Expressions of Interest before the end of 2011.

Judith also outlined the context of the Roundtable including the following:

- Program 3 aims to make a contribution towards the development of a good body of knowledge that will enable government and the community health sector to plan and implement better systems;
- to get below the 'business as usual' idea and discover levers for change;
- to understand what workforce resources are needed for good practice in recruitment and retention;
- to develop policy instruments for improving capacity with the health industry; and

- to use previous research such as Better Hospital Care project currently implemented at St Vincent's hospital in Melbourne to demonstrate and improve effectiveness and capacity within the health workforce.

Targeted workforce research has the potential to contribute on several levels to knowledge, resources and models and or tools to assist both the Aboriginal community controlled health sector (ACCHOs) and the health industry in general.

Presentation Abstracts

Presentation slides are available in Appendix 1, p.10

What do we need to know about workforce?

Professor Cindy Shannon

The current political context of `Close the Gap' is really building on 1989 Health Strategy work. At the Institute for Urban Indigenous Health, based in Brisbane, the focus is the entire health workforce. The 2004 Australian Medical Association (AMA) report card estimated that there was a need for 880 additional health professionals—the education pipeline into Indigenous health is not growing. The Council of Australian Governments (COAG) committed $171m over four years to workforce but we need models that deliver good outcomes, address clinical and non-clinical roles, and address urban/remote issues. There is concern about the role of Aboriginal Health Worker (AHW) training and recognition. The Department of Health has 300 employees.

Size and Impact

There are approximately 950 remote communities with less than 100 people each across the Northern Territory, Western Australia and Queensland. South-east Queensland has a population of about 50,000 Aboriginal and Torres Strait Islander people, more than the whole of Victoria.

The workforce stream at the Indigenous Urban Health Institute starts early, at least undergraduate—and perhaps secondary school. There is a need to develop multi-campus clinical networks, to have clinical guidelines for decision-making in Aboriginal and Torres Strait Islander health. We need to look at the barriers and enablers for uptake by Aboriginal Health Services of COAG reforms; to set benchmarks, for example, in education.

Research

What is the impact of the `new workforce'? What is the role of AHWs? Which service models facilitate successful workforce approaches?

Workforce planning

Workforce focus within health services research—to fix things you always come back to workforce. What are the skills enhancement needed? There is no evidence to justify the resources going into general practice. The issue of workforce needs was not discussed adequately with the National Aboriginal Community Controlled Health Organisation (NACCHO) and ACCHOs.

Challenges in workforce policy and planning

Mr Romlie Mokak

Pathways and pipeline; the new workforce = outreach, tobacco and lifestyle workers. They are, in a sense, a parallel workforce to the ACCHO workforce. So where are we on the mainstream agenda?

Relationship with National Health Practitioners Regulation Authority, Health Workers Australia and Aboriginal and Torres Strait Islander Workforce Strategic Framework—there should be no cherry-picking by mainstream. We need a collective health lobby that brings together the peak bodies and the professional association. The Indigenous VET sector has offered alternative pathways with RPL and articulation; vertical integration of medical and education training, supporting and connecting health leadership.

Accountability frameworks required for the non-Indigenous systems to be accountable. The strategies for retention in our area has been the connection between the Aboriginal Medical Services and tertiary institutions. Cultural safety was non-negotiable. The AMA included the working of sovereignty. We are all evidence-building in this work—where there isn't evidence articulated.

Supporting workers – What's the long-term view

Mr Tom Brideson

Presentation to discuss the acute areas at community level in relation to community mental health teams in NSW. There are 30 staff members in the Far Western Health District. There is a `Psychiatry Monitoring project' that has disaster plans layered over cultural frameworks; see <www.health.nsw.gov.au>.

Aboriginal mental health worker workplace learning placements through the university are part of strategy to grow workforce locally, which contributes to recruitment and retention. The award is a two-way process educating mental health staff about Aboriginal history and issues, celebrating success, defining the workforce. We want to be proactive rather than reactive and on the back foot.

General Discussion

After the presentations, a general discussion took place around suggestions for possible research. The following themes were agreed for discussion within small breakout groups:

1. pipeline and pathways
2. new workforce – existing workforce
3. workforce planning
4. workplace learning.

The breakout groups were asked to develop their theme into a research proposal and then into a marketing proposal to be presented to the main meeting. Roundtable participants were asked to vote on the best research proposal.

1. Group Presentation

Theme: Pipeline and Pathways

Topic: How do we measure the effectiveness of Aboriginal knowledge on patient care?

Presented by Alwin Chong (2 participants)

Rationale:

Limited workforce – may not fill the demand
Experienced health workers are in demand by other sectors
The drainage of workers is not being replaced
Registration with definite roles/ responsibilities.

Who:

Inclusive – State, NGOs, ACCHOs, AMIC, SEWB & Mental Health
What would you investigate?
Well thought through career pathways
What is the future of the ACCHOs?
How do you know if the employment strategy is working?
Evaluate effectiveness.

Outcomes:

How would this knowledge be agreed?
Measure the effectiveness of Aboriginal knowledge on patient care
Develop career pathways.

2. Group Presentation

Theme: New workforce – Existing Workforce:

Topic: Impact of closing the gap – Initiating on the workforce for local health service delivery to Aboriginal people

Presented by Christine Ross (5 participants)

Rationale:

Descriptive information of 'old' and 'new' workforce

Who are they?

Where are they?

Identify the unintended but foreseeable consequences of creating new workforce categories

Ensure future funding initiatives that build on the existing workforce i.e. don't create another position that already exists.

Outcomes:

Get rid of duplication with new initiatives.

3. Group Presentation

Theme: Workforce planning

Topic: How systems support effective workplace learning for effective Aboriginal and Torres Strait Islander Health

Presented by Janine Englehardt (5 participants)

Rationale:

a) Identify the workforce to achieve equality in health outcomes for Aboriginal and Torres Strait Islander people.

b) Elements to investigate:

- investing in areas for optimal health gain
- establishing a workforce model(s) in Primary Health Care, as well as acknowledging social and cultural determinants
- financing frameworks that flexibly respond to community identified needs
- connecting health education, training and service delivery horizontally and vertically with quality outcomes and focus
- identification of Aboriginal and Torres Strait Islander workers in all collections
- analysis and monitoring against targets.

Outcomes

In a timely fashion

Influence policy/programs effort across portfolios/agencies/politicians

Having agreed measures. Preferred indicators – accountability

Provide communities/services with and as an advocacy tool.

4. Group Presentation

Theme: Workplace Learning:

Topic: How systems support/effect workplace learning for effective Aboriginal and Torres Strait Islander health

Presented by Jenny Brands (6 participants)

Rationale:

What would be investigated: Strengths based. Existing models, across jurisdictions, tertiary and primary disciplines?

Develop sustainability and continuous improvement models.

How applied:

Stage 2: applying to other settings and what is required to support that wider application.

Outcomes:

More appropriately skilled with better retention rates. Workforce to be more client-focused and less burn out. A more collaborative approach is needed.

Synthesis and checking of results

There was a general discussion and voting after each presentation, participants were then asked to vote by scoring their preferred topic with a gold dot (2 points) for their first preference and a red dot (1 point) for their second preference.

1. Pipelines and Pathways (2 gold, 1 red)	5 points
2. New Workforce and Existing Workforce (8 gold, 2 red)	18 points
3. Workforce Planning (5 gold, 8 red)	18 points
4. Workplace Learning (4 gold, 8 red)	16 points

The votes favored New Workforce and Existing Workforce (2) followed by Workforce Planning (3).

The Next Step

Judith explained the next step: Further discussions within the program area will now follow with a decision on what will be possible. Participants will receive the notes taken from the Roundtable including PowerPoint presentations.

- Once the research proposals are develop input from participants will be required.
- There will be a call within the Lowitja Institute partnership for expressions of interest to conduct the research.
    - The expression of interest document is available from the Lowitja Institute website at <http://www.lowitja.org.au/announcements/call-expressions-interest-two-workforce-policy-projects>.

Workshop closed: Leilani thanked everyone for attending and handed over to Alwin Chong to close the Roundtable; Alwin also thanked participants for their input. He thanked Leilani for facilitating and Vanessa Harris and Cheryl Cole for organising the Roundtable on behalf of himself and Judith.

Appendix 1: Presentations Slides

What do we need to know about workforce?

Professor Cindy Shannon

Workforce Shortfall

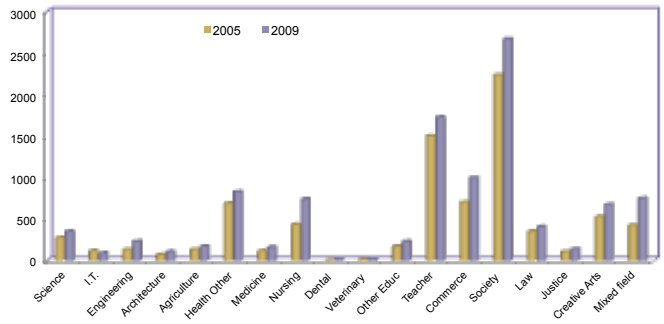
- AMA estimates (2004) based upon methodology developed by Access Economics:
  - Additional 880 health professionals needed to address critical shortages in Indigenous health (430 doctors and 450 other health professionals)
  - Estimated cost of $36.5m/year ($167m over 6 years)

Indigenous worker shortage in the general workforce (AMA 2004):

	Numbers in 2001	Pro Rata	Gap
Medical Imaging	**14**	**163**	**149**
Dentists	**13**	**174**	**161**
Nurses	**789**	**3359**	**2570**
Pharmacists	**10**	**285**	**275**
Occupational Therapists	**7**	**126**	**119**
Optometrists	**5**	**64**	**59**
Physiotherapists	**29**	**242**	**213**
Aboriginal health workers	**853**	**2000**	**1147**

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

Number of all Aboriginal and Torres Strait Islander students by broad field of education, 2005-2009



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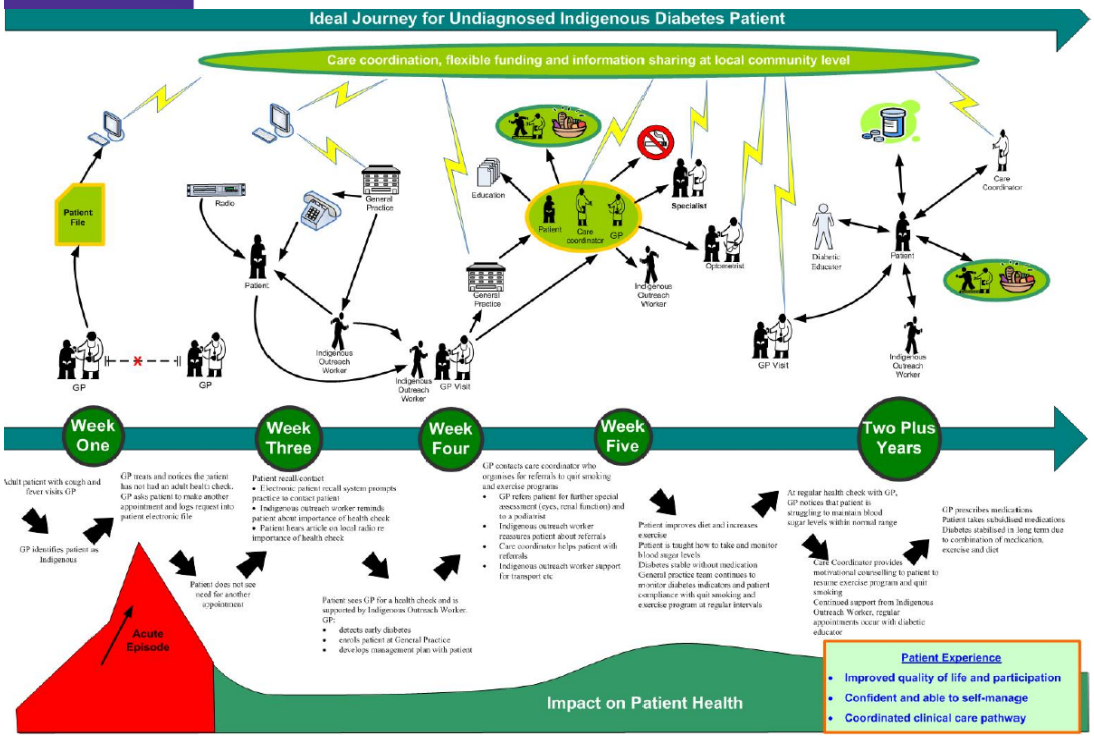
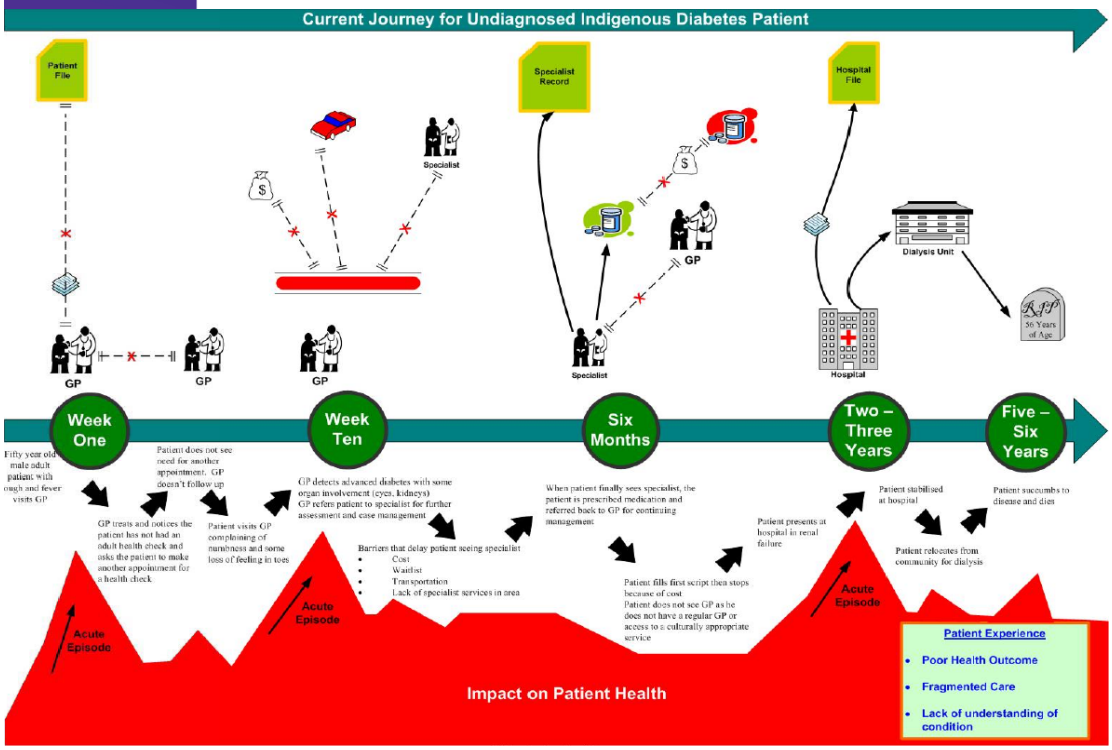
Close the Gap : $171million over 4 years

- Workforce Education and Training
- Expanding the Outreach and Service Capacity of Indigenous Health Services
- Improving Indigenous Access to Mainstream Primary Health Care
- A National Recruitment Campaign
- Clinical practice guidelines for working with Aboriginal and Torres Strait Islander peoples

What are we trying to achieve? Ideal Journey



What are we trying to achieve? – Current Journey

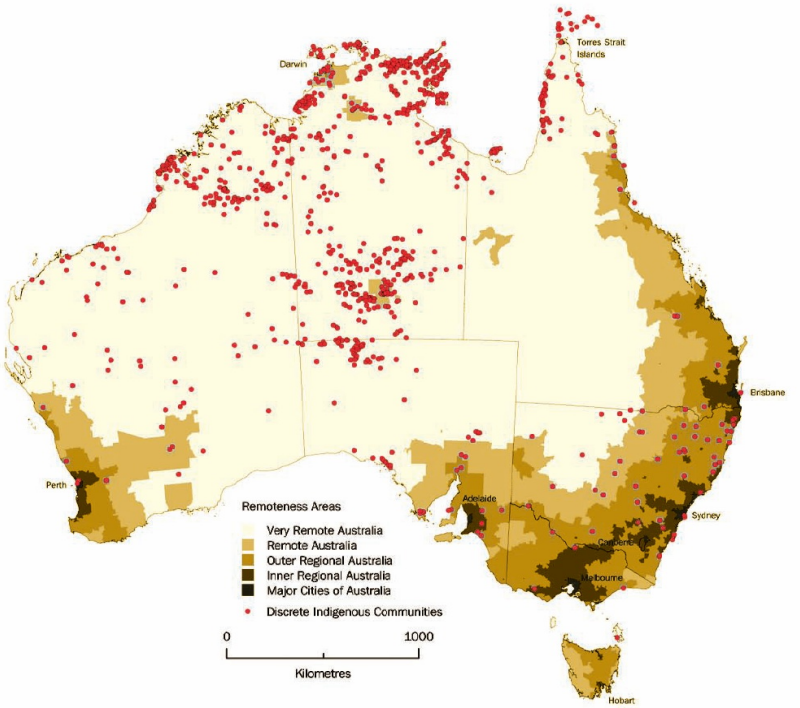


Role of the Aboriginal Health Worker

- Implications of Government policy
  - Areas of specific policy development
  - Role of workforce planning
  - COAG reform agenda

- Implications of registration
  - Clinical and non-clinical roles
  - Urban/remote issues

UQ Indigenous Strategy Workshop



UQ Indigenous Strategy Workshop

UQ Indigenous Strategy Workshop

Urban Indigenous populations Put into perspective....

- The Aboriginal and Torres Strait Islander population of SEQ is:
  - Greater than the entire Indigenous population of Victoria
  - Greater than the entire Indigenous population of SA
  - About 2/3 the total Indigenous population of the NT
  - More than half the total Indigenous population of WA

Workforce Comparisons

Service	Pop Base	Dr : Ind Pop	Nurse : Ind Pop	AHW : Ind Pop
TAIHS*	5846	1:191	1:2973	1:2973
SCAMSAC*	1204	1:1204	1:1204	1:1204
NHC*	2833	1:1416	1:118	1:104
IUIH 1	27059	1:6440	1:3656	1:3006
IUIH 2	5382	1:2691	1:2691	1:1345

*Based on 2001/02 data

UQ Indigenous Strategy Workshop

What was needed in SEQ

- Map current status of Indigenous Health and Education within UQ Faculty of Health Sciences
- Set targets / aims of Indigenous Health and Education within the curricula of UQ Faculty of Health Sciences for what we would like to achieve
- Identify and implement evidenced-based strategies to implement, monitor and review Indigenous Health and Education within the Faculty of Health Sciences
- Funding for the employment of a workforce coordinator with IUIH

UQ Indigenous Strategy Workshop

What will be achieved

- Capacity Planning and Programming
  - Establish multi-campus teaching centre (Inala first node)
  - Establish Clinical guidelines
- Workforce Recruitment and Development
  - Establish additional registrar posts and nursing placements in Indigenous health services
- Workforce Research
  - Research programs on workforce perceptions, barriers and expectations
  - Establish appropriate workforce benchmarks for urban services

Student Recruitment and Retention targets for clinical placements within Aboriginal and Torres Strait Islander Medical Services in South East Queensland – The University of Queensland

Field	Rotations	No. Students	Total	Year
Medicine	4	2	8	2010
	4	4	16	2011
	4	6	24	2012
Allied Health	2	4	8	2010
	2	8	16	2011
	2	12	24	2012
Dental	2	2	4	2010
	2	4	8	2011
	2	6	12	2012
Total:	24	48	120	

In terms of research:

- Impact of the "new workforce"
- Continuing role of the Aboriginal health worker
- Service models that facilitate successful workforce approaches
- Appropriate models for workforce planning
- Workforce focus within health services research

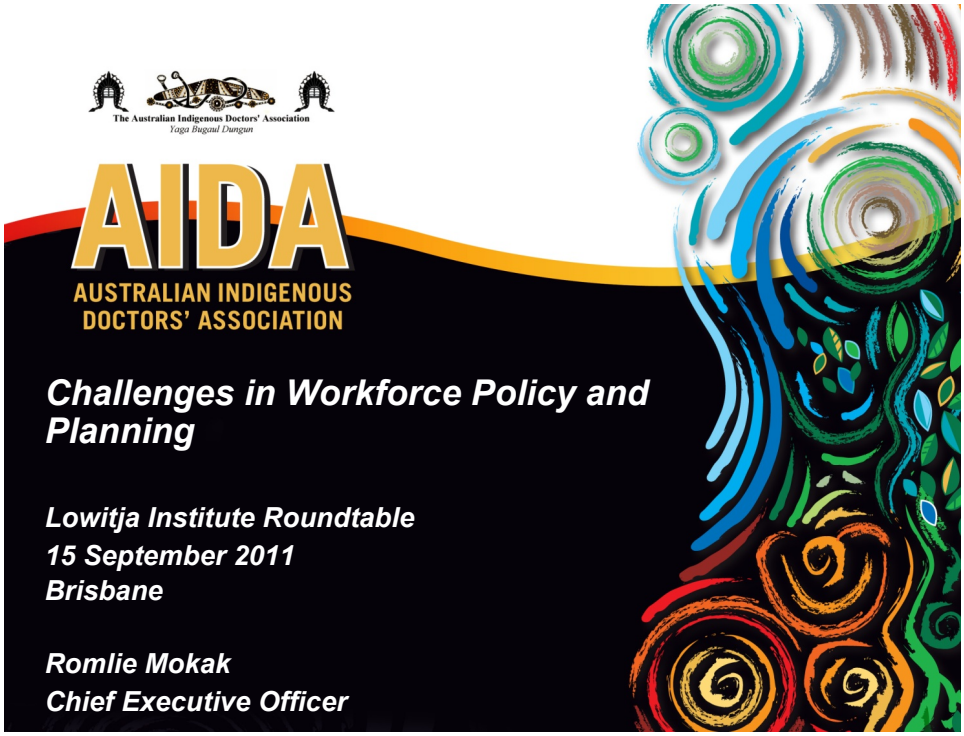
Thank You

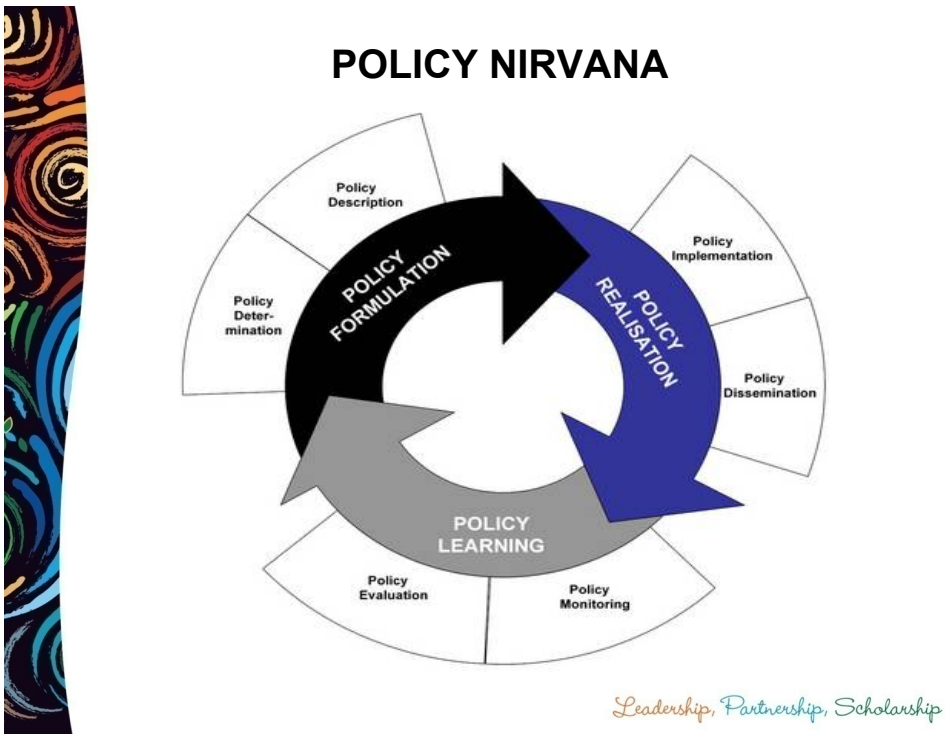
c.shannon@uq.edu.au

UQ Indigenous Strategy Workshop

Challenges in workforce policy and planning

Mr Romlie Mokak





REFORM BUFFET

- Primary Care Strategy
- National Preventative Health Taskforce
- National Health and Hospital Reform Commission
- National Health and Hospitals Network
- Medical Locals
- Local Hospital Networks
- Closing the Gap
- NIRA/NPAs
- And the rest....

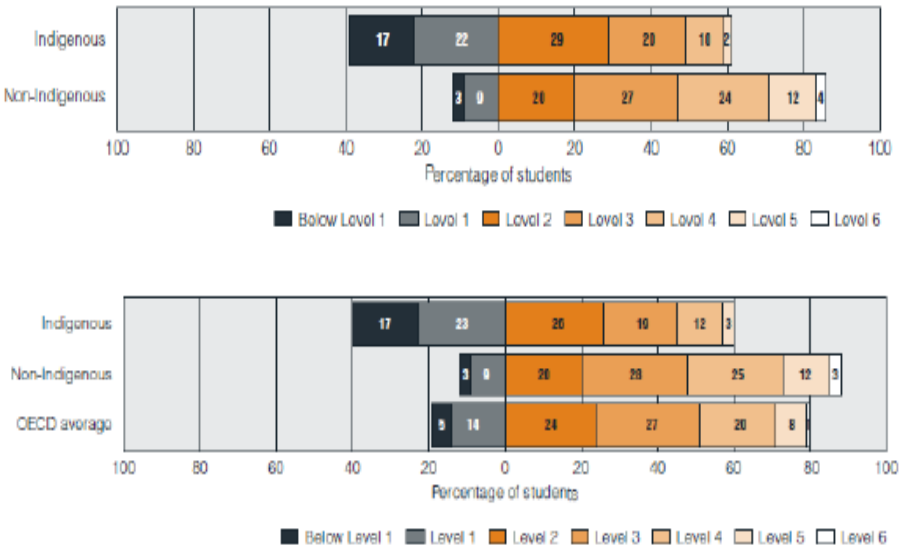
Leadership, Partnership, Scholarship

HEALTH WORKFORCE SMORGASBORD

- Health Workforce Australia
- Australian Health Practitioners Regulation Authority
- National Aboriginal and Torres Strait Islander Training Package
- NIHEC Workforce Forums
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework
- Aboriginal and Torres Strait Islander Professional Associations
- Indigenous Education Action Plan
- Indigenous Economic Development Strategy

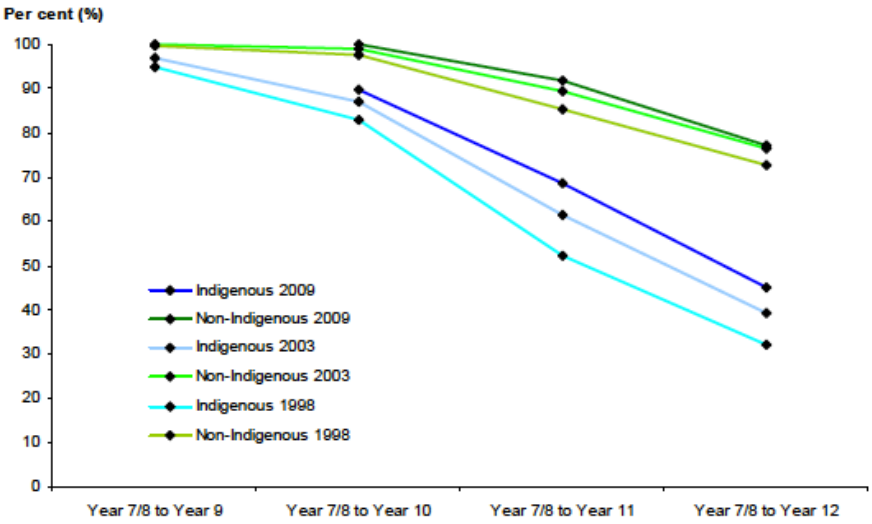
Leadership, Partnership, Scholarship

PISA 2006 MATHS/SCIENCE LITERACY



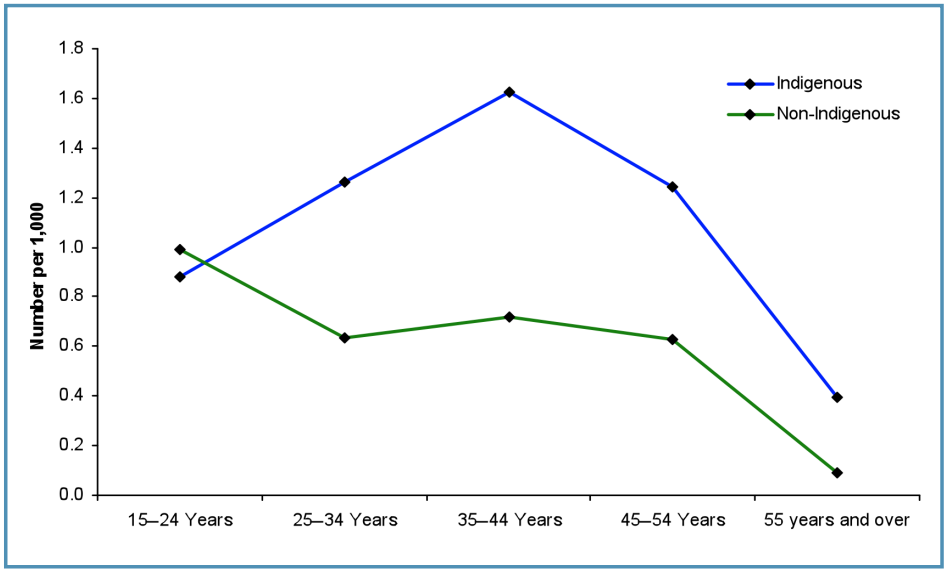
Leadership, Partnership, Scholarship

7 -12 RETENTION



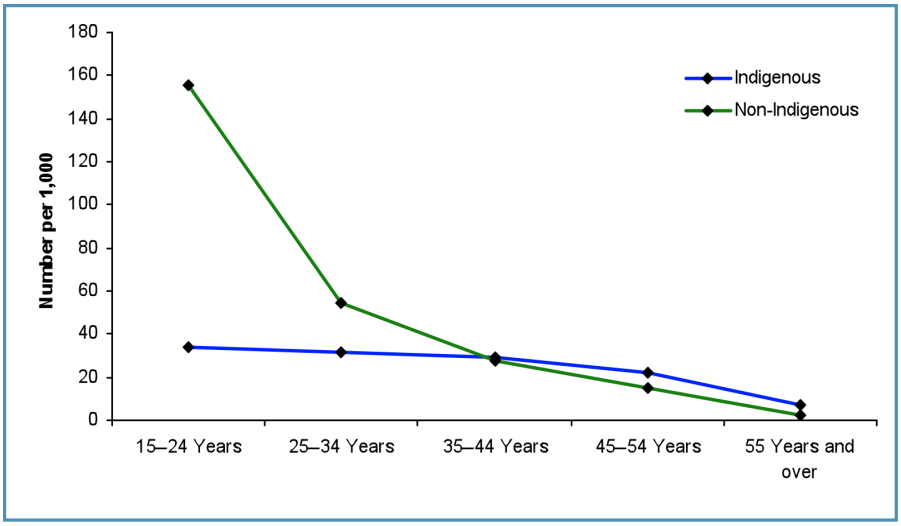
Leadership, Partnership, Scholarship

HEALTH RELATED VET SECTOR COMPLETIONS, 2007



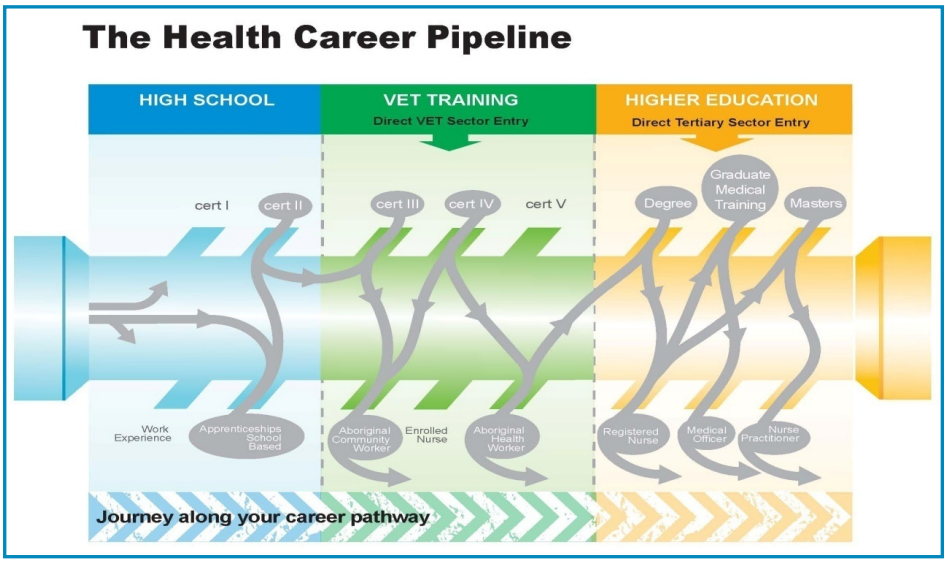
Leadership, Partnership, Scholarship

HIGHER EDUCATION HEALTH RELATED COURSE ENROLMENTS 2006



Leadership, Partnership, Scholarship

HEALTH WORKFORCE PIPELINE



Leadership, Partnership, Scholarship

ABORIGINAL AND TORRES STRAIT ISLANDER DOCTORS

- Professor Helen Milroy first Aboriginal doctor, 1983 (century after Maori, Native American etc..)
- By 1993, only another 7 graduate medicine
- In 2010:
  - 150 graduates
  - 160 students
- Most in General Practice (over 45 in training)
  - Surgeon x 1
  - Psychiatrist x 2
  - Obstetrician x 1
  - Cardiologist x 1
  - Paediatrician x 0
  - Ophthalmologist x 0
- Vertical integration med ed/ training
- Supporting/connecting orgs in health leadership
- Accountability frameworks

Leadership, Partnership, Scholarship

Leadership, Partnership, Scholarship

KEY INTERVENTION POINTS

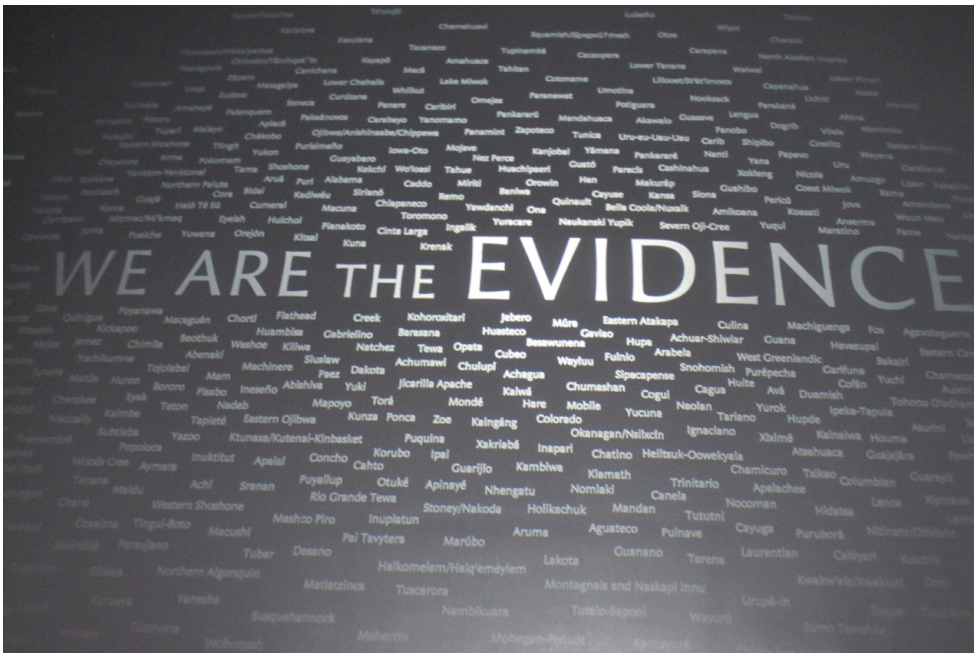
- Build the secondary school pipeline
- Build the articulation between the VET sector, health workforce & higher education
- Increase higher education completions
- Performance measurement
- Health system strategies for retention

Leadership, Partnership, Scholarship

NGANGKARI AT MOADOPH

Leadership, Partnership, Scholarship

ENDURING EVIDENCE



Leadership, Partnership, Scholarship

Supporting workers – What is the long-term view?

Mr Tom Brideson

Overview

- Who am I, my motivations and the struggle
- Evidence building where it doesn't exit
- Aboriginal Health environment
- Changing the landscape
- Workforce dreaming

Aboriginal Health Workforce

- In 2006 Indigenous Australians were under-represented in almost all health-related occupations and comprised 1% of the health workforce.
- Indigenous students were also under-represented among those completing graduate courses in health (approx 1%).

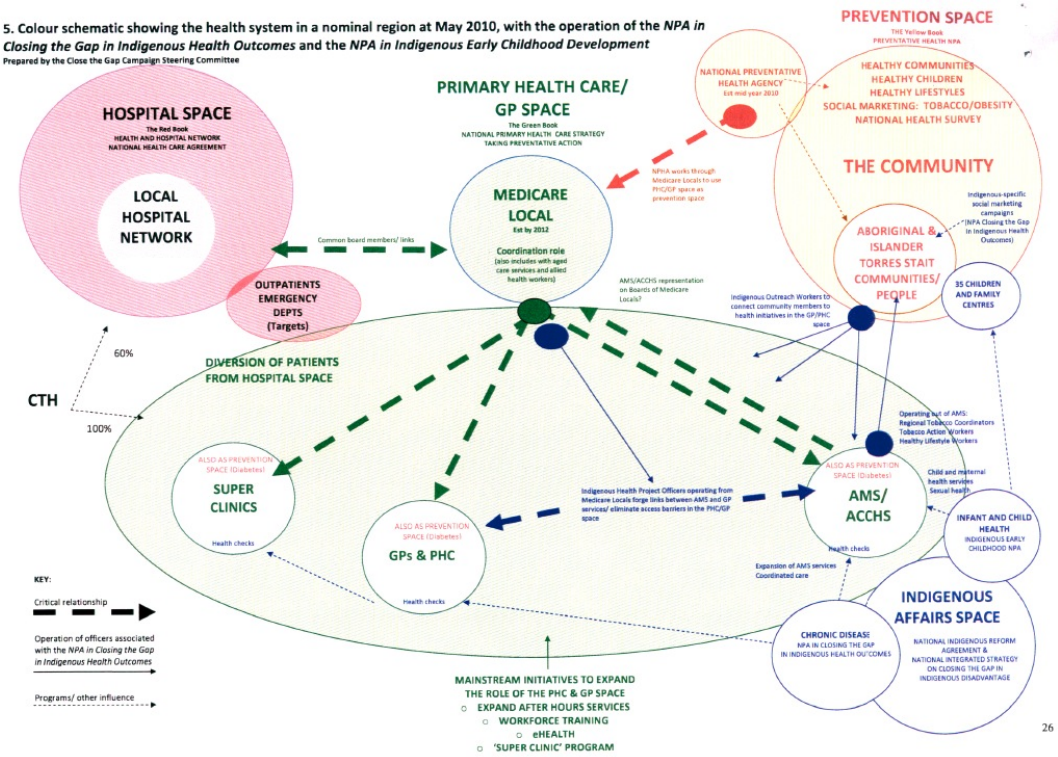
ABS 2008

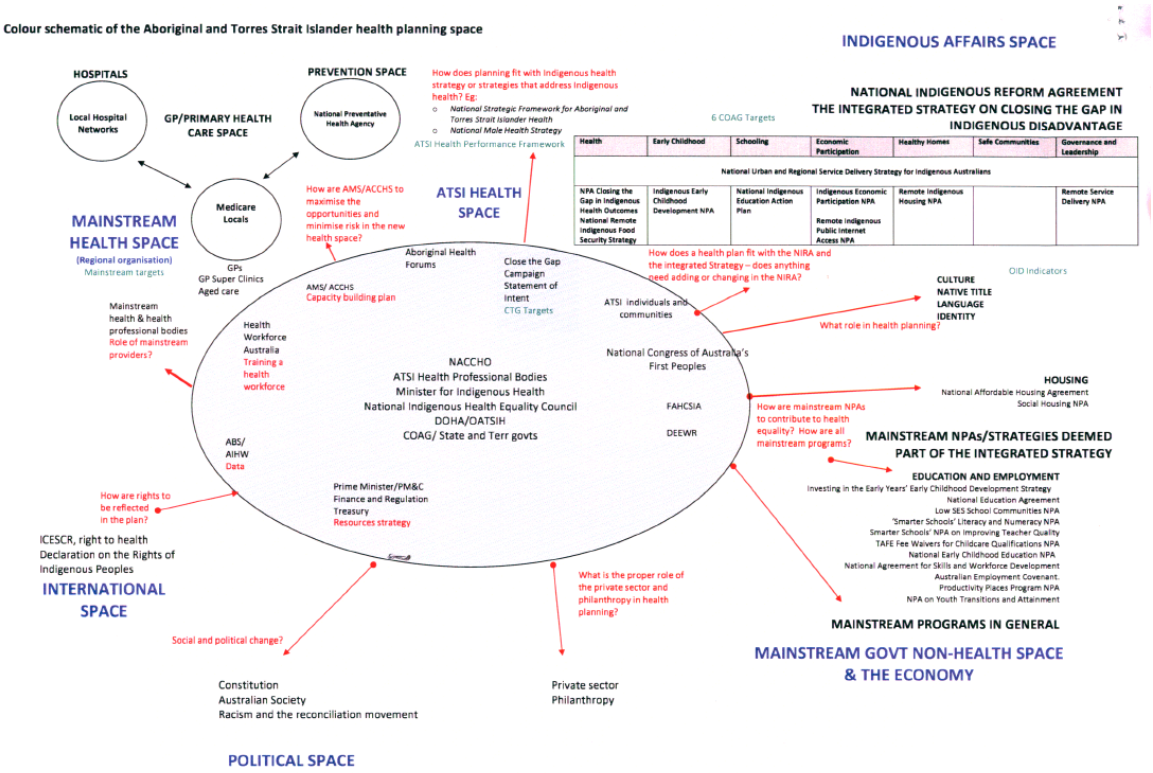
Expectations Consumers/Carers

- What should Aboriginal consumers and carers expect from MH Professionals?
  - The best possible treatment
  - Respectfulness
  - A genuine understanding
  - Choice and timeliness
  - Help to meet their needs

5. Colour schematic showing the health system in a nominal region at May 2010, with the operation of the *NPA in Closing the Gap in Indigenous Health Outcomes* and the *NPA in Indigenous Early Childhood Development*

Prepared by the Close the Gap Campaign Steering Committee




Colour schematic of the Aboriginal and Torres Strait Islander health planning space
INDIGENOUS AFFAIRS SPACE
HOSPITALS
Local Hospital Networks
GP/PRIMARY HEALTH CARE SPACE
PREVENTION SPACE
National Preventative Health Agency
How does planning fit with Indigenous health strategy or strategies that address Indigenous health? Eg:
National Strategic Framework for Aboriginal and Torres Strait Islander Health
National Male Health Strategy
ATSI Health Performance Framework
NATIONAL INDIGENOUS REFORM AGREEMENT
THE INTEGRATED STRATEGY ON CLOSING THE GAP IN INDIGENOUS DISADVANTAGE
6 COAG Targets
Health
Early Childhood
Schooling
Economic Participation
Healthy Homes
Safe Communities
Governance and Leadership
National Urban and Regional Service Delivery Strategy for Indigenous Australians
NPA Closing the Gap in Indigenous Health Outcomes
National Remote Indigenous Food Security Strategy
Indigenous Early Childhood Development NPA
National Indigenous Education Action Plan
Indigenous Economic Participation NPA
Remote indigenous Public Internet Access NPA
Remote Indigenous Housing NPA
Remote Service Delivery NPA
MAINSTREAM HEALTH SPACE
(Regional organisation)
Mainstream targets
Medicare Locals
How are AMS/ACCHS to maximise the opportunities and minimise risk in the new health space?
ATSI HEALTH SPACE
GPs
GP Super Clinics
Aged care
Aboriginal Health Forums
Close the Gap Campaign Statement of Intent
CTG Targets
AMS/ ACCHS
Capacity building plan
How does a health plan fit with the NIRA and the integrated Strategy – does anything need adding or changing in the NIRA?
OID Indicators
CULTURE
NATIVE TITLE
LANGUAGE
IDENTITY
What role in health planning?
ATSI individuals and communities
Mainstream health & health professional bodies
Role of mainstream providers?
Health Workforce Australia
Training a health workforce
NACCHO
ATSI Health Professional Bodies
Minister for Indigenous Health
National Indigenous Health Equality Council
DOHA/OATSIH
COAG/ State and Terr govts
National Congress of Australia's First Peoples
FAHCSIA
DEEWR
HOUSING
National Affordable Housing Agreement
Social Housing NPA
How are mainstream NPAs to contribute to health equality? How are all mainstream programs?
MAINSTREAM NPAs/STRATEGIES DEEMED PART OF THE INTEGRATED STRATEGY
ABS/ AIHW
Data
EDUCATION AND EMPLOYMENT
Investing in the Early Years' Early Childhood Development Strategy
National Education Agreement
Low SES School Communities NPA
'Smarter Schools' Literacy and Numeracy NPA
Smarter Schools' NPA on Improving Teacher Quality
TAFE Fee Waivers for Childcare Qualifications NPA
National Early Childhood Education NPA
National Agreement for Skills and Workforce Development
Australian Employment Covenant.
Productivity Places Program NPA
NPA on Youth Transitions and Attainment
How are rights to be reflected in the plan?
Prime Minister/PM&C
Finance and Regulation
Treasury
Resources strategy
ICESCR, right to health
Declaration on the Rights of Indigenous Peoples
INTERNATIONAL SPACE
What is the proper role of the private sector and philanthropy in health planning?
MAINSTREAM PROGRAMS IN GENERAL
MAINSTREAM GOVT NON-HEALTH SPACE & THE ECONOMY
Social and political change?
Constitution
Australian Society
Racism and the reconciliation movement
Private sector
Philanthropy
POLITICAL SPACE

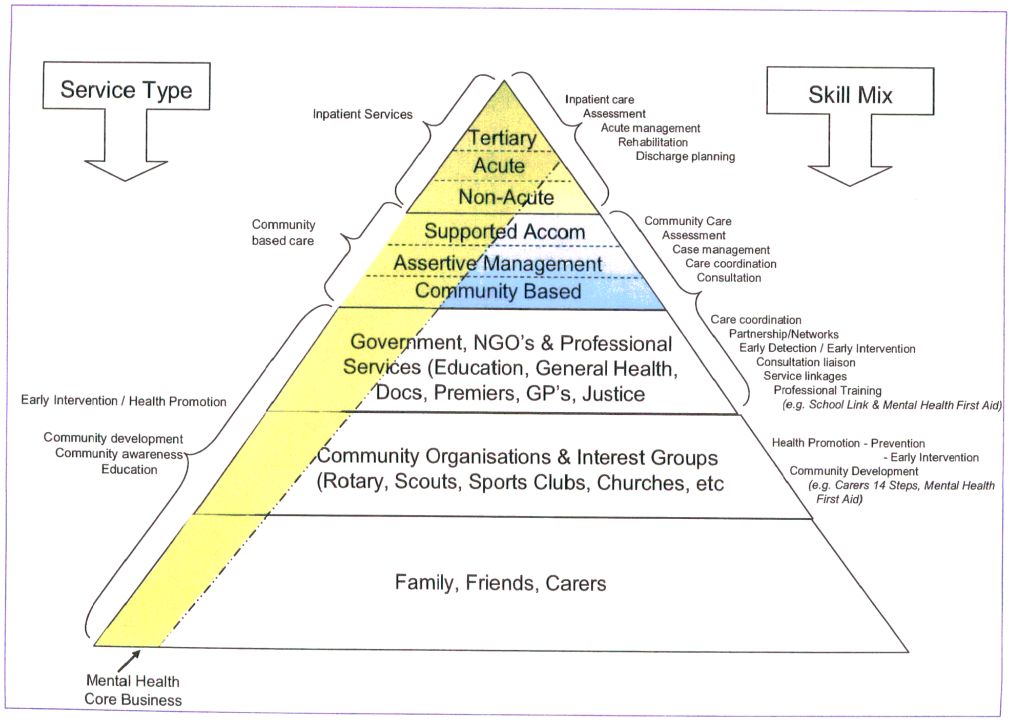


Figure 6: Greater Western AHS MHDA Core Business (Roberts, 2007)

Program Publications

Jones, Carmel and Brideson, Tom (2009) *'Using policy and workforce development to address Aboriginal mental health and wellbeing'*, Australasian Psychiatry, 17:1, S72 — S74

Watson, Carol and Harrison, Nea (2009) *New South Wales Aboriginal Mental Health Worker Training Program: Implementation Review.* Cooperative Research Centre for Aboriginal Health and NSW Health

http://www.lowitja.org.au/files/crcah_docs/NSW%20Training%20Manual%20interactive.pdf

Watson, Carol and Harrison, Nea with Brideson, Thomas and Greenwood, Catherine (2010) *Walk Together, Learn Together, Work Together: A Practical Guide for the Training of Aboriginal Mental Health Professionals in New South Wales.* Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

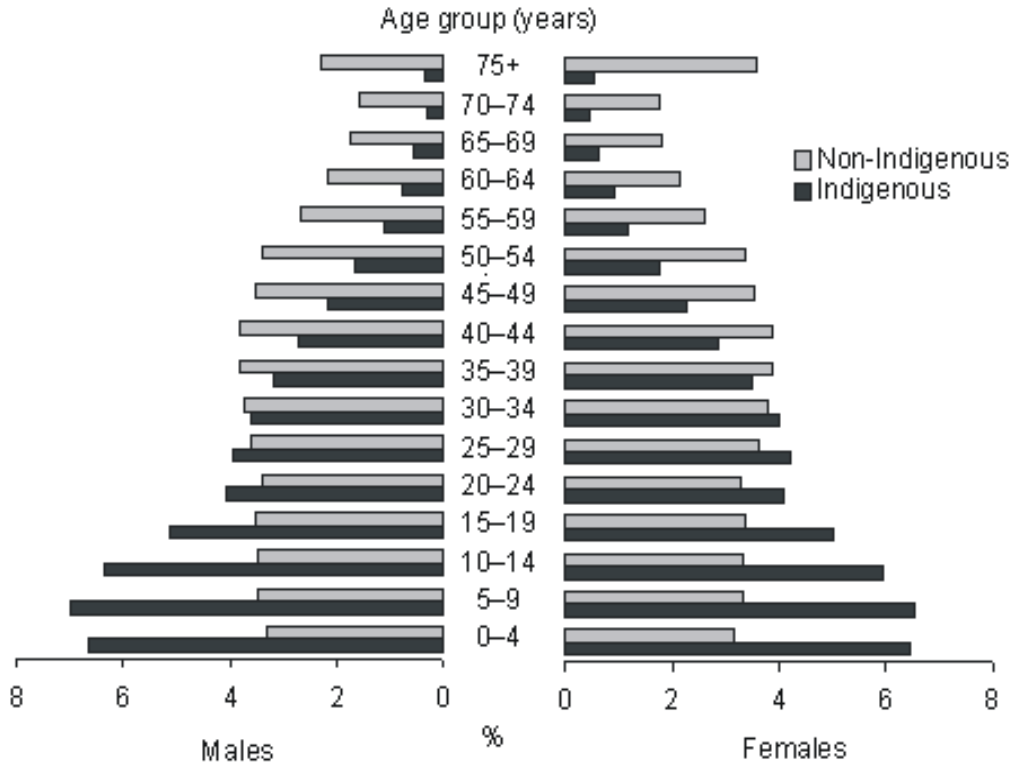
http://crrmh.com.au/Aboriginal-Mental-Health-Workers-Training-Program/

Limited Statistics that we know

- Higher levels of psycho social distress
- Higher levels of Suicide and Self Harm
- Higher levels of acute MH admissions (x3)

- Higher levels of
  - Health problems
  - Social disadvantage

- Lower levels of
  - Life expectancy
  - Educational outcomes



Changing the landscape

- There has to be a better story
- Linking with existing services/programs
- Making sustainable relationships
- Making the story relevant
- Building evidence where it doesn't exist
- Supporting existing programs through an evidence base

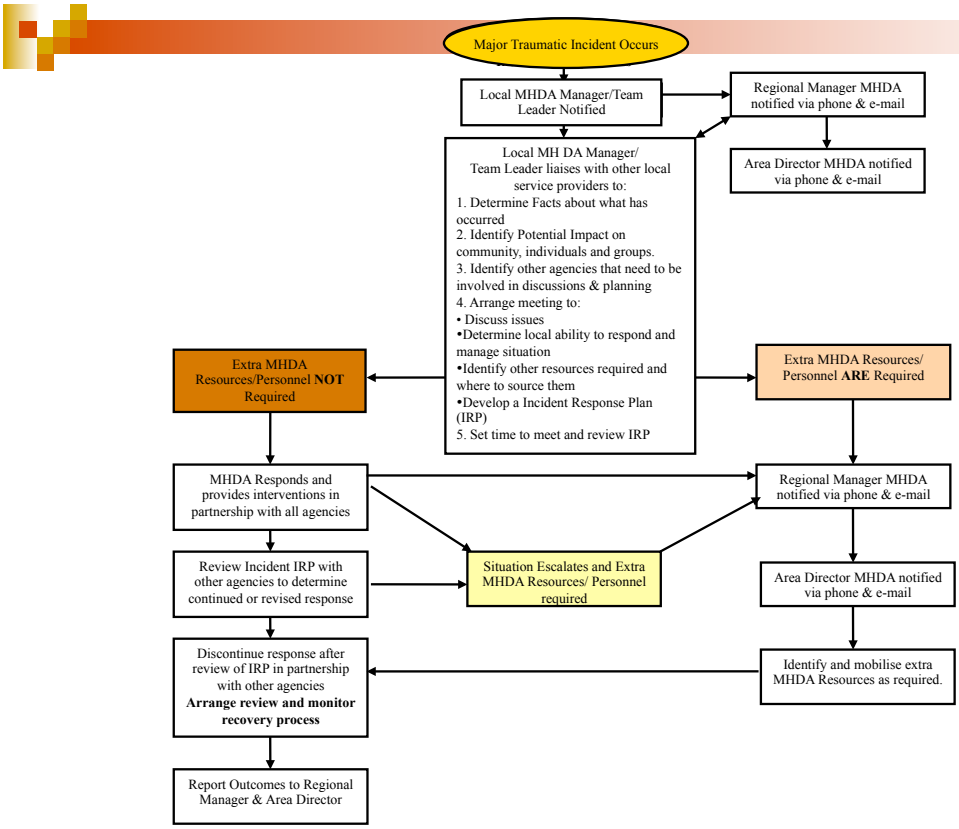
Western and Far Western Local Health Districts, NSW

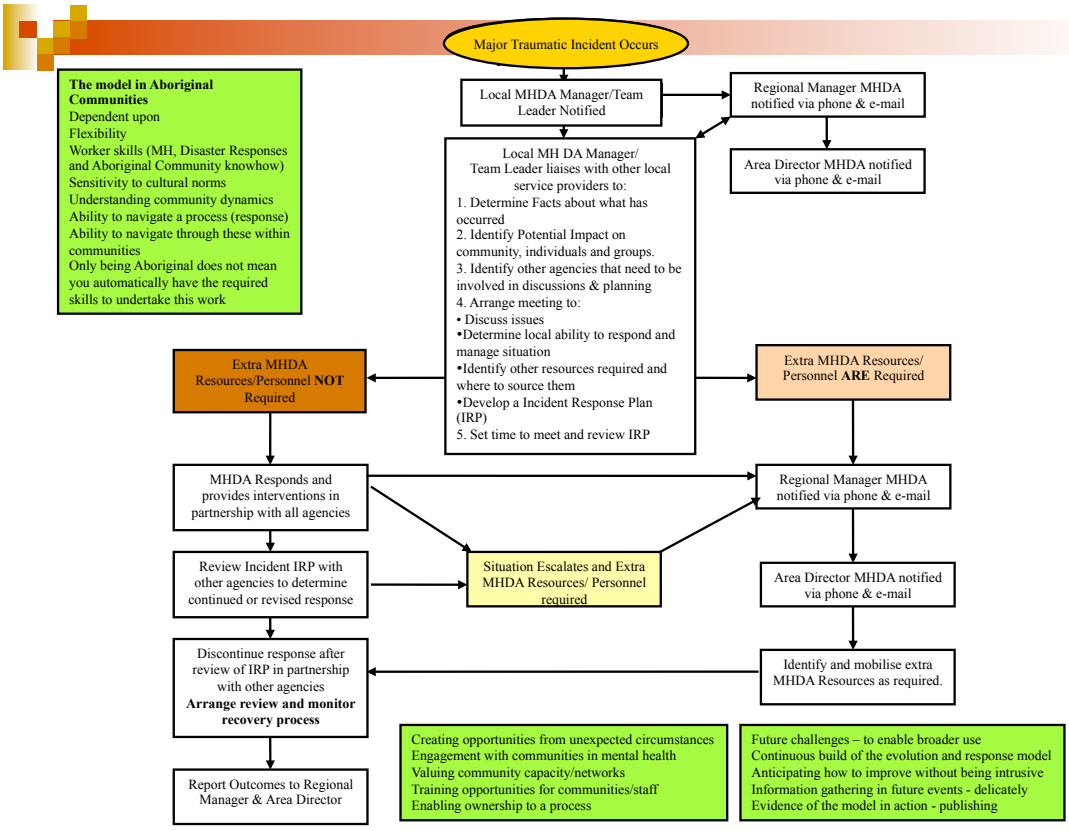
- Aboriginal publication agenda
  - Responding to adversity
  - Psychiatry mentoring project
  - Aboriginal Management Committee
  - Practical Guide development (NSW)
  - Aboriginal managers of MH Services
  - Older Aboriginal Persons project

Example One

Community Incidents

Community 1	Community 2	Community 3
Death of a child	Multiple Suicides	House fire
Multiple Family issues	People related	Grandfather/Grandchild
Complex set of issues	Limited services	Lots of witnesses
Known to service	Reasonably isolated	Limited services
High Aboriginal population	High Aboriginal population	High Aboriginal population
Common issues/threads		
High numbers and/or % of Aboriginal people in Communities Beyond the usual incident, highly emotive and stretches local capacity Local (Aboriginal) workers immersed in community and incidents Support was required for services to do what they need to do		


Major Traumatic Incident Occurs
Local MHDA Manager/Team Leader Notified
Regional Manager MHDA notified via phone & e-mail
Area Director MHDA notified via phone & e-mail
Local MH DA Manager/ Team Leader liaises with other local service providers to:
1. Determine Facts about what has occurred
2. Identify Potential Impact on community, individuals and groups.
3. Identify other agencies that need to be involved in discussions & planning
4. Arrange meeting to:
• Discuss issues
•Determine local ability to respond and manage situation
•Identify other resources required and where to source them
•Develop a Incident Response Plan (IRP)
5. Set time to meet and review IRP
Extra MHDA Resources/Personnel NOT Required
Extra MHDA Resources/ Personnel ARE Required
MHDA Responds and provides interventions in partnership with all agencies
Regional Manager MHDA notified via phone & e-mail
Review Incident IRP with other agencies to determine continued or revised response
Situation Escalates and Extra MHDA Resources/ Personnel required
Area Director MHDA notified via phone & e-mail
Discontinue response after review of IRP in partnership with other agencies
Arrange review and monitor recovery process
Identify and mobilise extra MHDA Resources as required.
Report Outcomes to Regional Manager & Area Director


Major Traumatic Incident Occurs
The model in Aboriginal Communities
Dependent upon
Flexibility
Worker skills (MH, Disaster Responses and Aboriginal Community knowhow)
Sensitivity to cultural norms
Understanding community dynamics
Ability to navigate a process (response)
Ability to navigate through these within communities
Only being Aboriginal does not mean you automatically have the required skills to undertake this work
Local MHDA Manager/Team Leader Notified
Regional Manager MHDA notified via phone & e-mail
Area Director MHDA notified via phone & e-mail
Local MH DA Manager/ Team Leader liaises with other local service providers to:
1. Determine Facts about what has occurred
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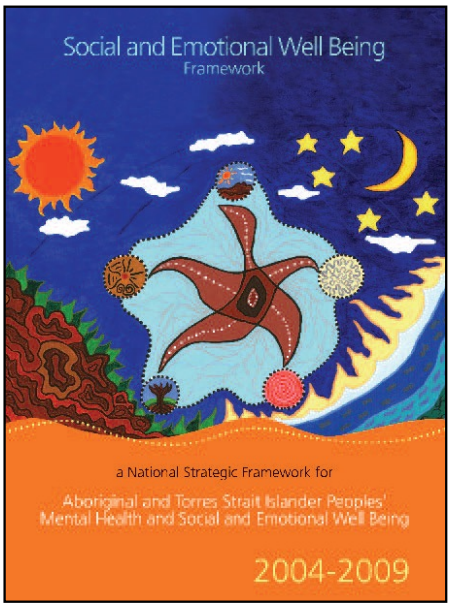
Arrange review and monitor recovery process
Identify and mobilise extra MHDA Resources as required.
Report Outcomes to Regional Manager & Area Director
Creating opportunities from unexpected circumstances
Engagement with communities in mental health
Valuing community capacity/networks
Training opportunities for communities/staff
Enabling ownership to a process
Future challenges – to enable broader use
Continuous build of the evolution and response model
Anticipating how to improve without being intrusive
Information gathering in future events - delicately
Evidence of the model in action - publishing

Why use the Disaster Plan?

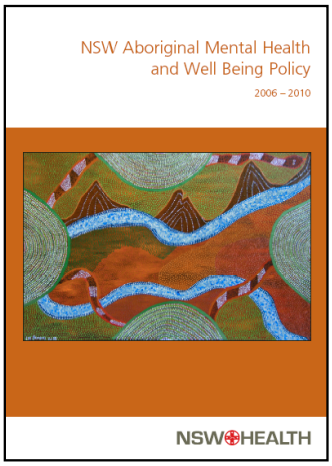
- By aligning this model to existing formalities of a mental health service response (disaster plans exist in every service) it enables the service to play a very important and active role at a local level which assists communities to deal with the incident during a very stressful time
  - It requires thought, planning, support and commitment
  - It gives services a framework to become involved which once activated engages the whole system
  - Communities and services want to connect better
  - It may be a point of future community intervention
  - It is a simple concept, sustainable and cost effective

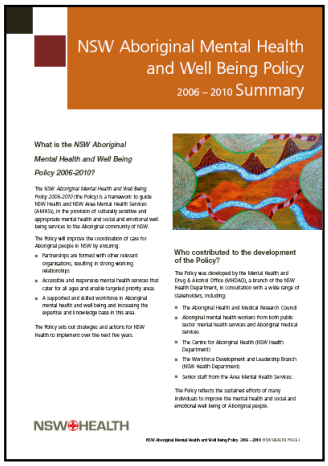
Example Two

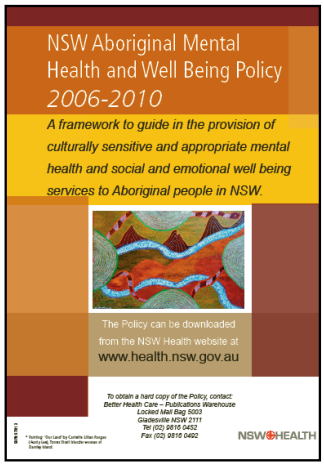
National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004 – 2009



NSW Aboriginal Mental Health and Well Being Policy 2006 - 2010







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Workforce Program directions

1. Increase the Aboriginal mental health workforce;
2. Increase the quality of the workforce;
3. Increase the accessibility, responsiveness and effectiveness of mental health services;
4. Increase the number of Aboriginal people accessing mental health services; and,
5. Improve treatment outcomes for Aboriginal people who have mental health problems.

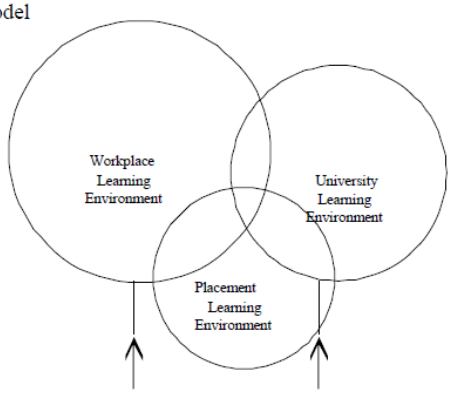
Program - Key Points

'At a Glance'

- Identified positions
- Funded as enhancements
- Trainees employed in all AHS's
- AHS's Recruit and Develop Trainees
- On the Job Training
- Linked to University Degree
- AHEO Award – non Graduate
- 3 year Traineeship
- Successful Completion - Ongoing Employment
- Transfer to Graduate AHEO or HP Award
- Success dependent upon AHS Leadership
- Practical Guide provides agreed implementation for Program
- Coordination & Implementation is monitored – S/W Coordinator

Aboriginal Mental Health and Drug and Alcohol Training Program

Learning Model



Mental Health Competencies

(Based on National Practice Standards for Mental Health Workforce 2002)

Aboriginal MHW are clinicians

- Almost 50 Trainees
- Negotiating a relevant award
- National Practice Standards MHW's
- Sustainability
- This is about the pointy end of care
- The role as a specialist role
- All 5 MH Professions have a poor record
- Growing a workforce 'locally'

Need and requirements

- NSW target is 1:1000
- We have the potential to make 850 in NSW over 51 years with no extra effort
- Culture is not the only criteria for this work
- The model is about recruitment/retention
- 4 cousins x 4 kids x 4 kids = 64 (how will the current effort respond to these kids?

Imagination?

- Breaking Down Barriers
- AMH Committee's of Relevance
- Cross Fertilisation
- Professional Marketability
- Complimentary v Supplementary
- Understanding Language
- Portable Skills

...Continued

- Building Worker Capacity
- Building a Critical Mass
- Boosting Organisations
- Professional Networks
- Educating the Workplace on community
- Educating the Community on MH
- Creating Better MH Responses

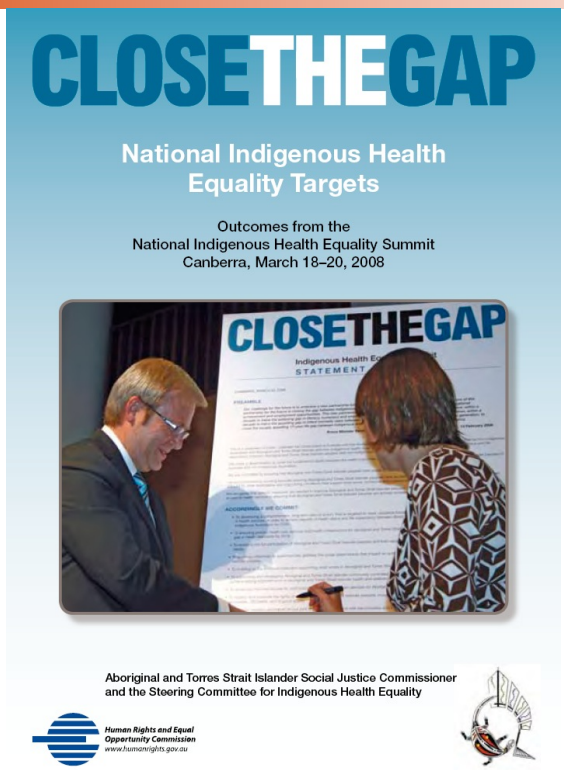
Future workforce dreaming

- Articulation - Professional Pathways
- Sustainable Long Term Solutions
- Building a Critical Mass
- Adequate Funding/Resoucing
- Quality Programs & Students
- Improved Supervision & Support
- A Variety of Models and Choice
- Meaningful career pathways

We should be thinking through

- What do we want in 20, 30, 50 years
- We need to honour the people before us
- Are there other ways of looking at this
- When do we celebrate success
- Building the value of existing programs
- Defining the workforce we want
- Working towards that goal

- 2.5%



= 2.5%

Contact

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Bloomfield Hospital
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Orange NSW 2800

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Fax 02 6362 8924

Appendix 2: Workshop Attendance List

PRESENT

Dianne Walker	The Lowitja Institute
Vanessa Harris	The Lowitja Institute
Elizabeth Orr	La Trobe University
Freda Masina	Mamu Health Service
John Willis	St Vincent's Hospital
Michelle Winters	St Vincent's Hospital
Della Yarnold	Northern Territory Clinical School
Robert Dann	Aboriginal Health Council of South Australia Inc.
Pat Maher	Health Workforce Australia
Christine Ross	Western Australia Department of Education
Barbara Pitman	Human Service Training Advisory Council
Janine Englehardt	National Aboriginal Community Controlled Health Organisation
Renee Williams	National Aboriginal Community Controlled Health Organisation
Harry Miller	Port Lincoln Aboriginal Health Service
Karen Mounsey	Apunipima Health Service
Alison Nelson	Institute for Urban Indigenous Health
Deborah Askew	Inala Indigenous Health Service
Chris Eldridge	Queensland Aboriginal and Islander Health Council
Jenny Brands	Menzies School of Health Research
Liz Izquierdo	The Lowitja Institute
Cheryl Cole	The Lowitja Institute (note taker)

APOLOGIES

Bronwyn Fredericks	Faculty of Health, Queensland University
Chris Sara	Queensland University of Technology
Clare Anderson	Australia Health Workforce Ministerial Council
Gail Garvey	Queensland Institute of Medical Research
Ruth Wallace	Pawinee Yahun
Eileen Willis	School of Medicine, Flinders University
Ian Crittenden	Health Workforce Australia
Mark Cormack	Health Workforce Australia
Anthony West	Aboriginal and Torres Strait Islander Health Brisbane
Haylene Grogan	Aboriginal and Torres Strait Islander Health Brisbane
Selwyn Button	Queensland Aboriginal and Islander Health Council
Braiden Abala	NT Department of Health
Cleveland Fagan	Apunipima Health Service
Judith McKay	Human Services Training Advisory Council NT

the Lowitja INSTITUTE

Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

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