An example of sound practice in the supervision and support of CBWs within an enabling work environment: Northern Territory (NT) Remote Alcohol and Other Drugs (AOD) Workforce Program

This Australian Government funded Remote AOD Workforce Program employs full time CBWs as AOD workers who are “embedded” in local primary health care services, both NT Department of Health and Aboriginal Medical Services, in a number of communities across the NT. The Program objective is to develop and implement a Remote AOD Workforce Program, based within a primary health care service that provides an AOD service to people who currently have limited access to AOD services and that is culturally appropriate, evidence based and sustainable.

This model of service delivery is a ‘hub and spoke’ model where central administrative and programmatic support is provided to CBWs in distant sites. AOD specialists (Clinical Supervisor, Clinical Nurse Mentor, Training and Education Officer, Program Support Officers and Program Manager) support the Program centrally and visit communities on a regular basis to provide on-the-ground service support and clinical supervision.

What do we do?

The Program Support Unit (PSU), experienced in AOD and mental health, developed a ‘Best Practice Model’ of service delivery and community development, informed by research and analysis of evaluations of four relevant NT AOD and Mental Health Programs. They identified three main challenges of implementing a workforce program employing CBWs within remote primary health care services: governance, sustainability and implementation of best practice. In order to ensure AOD workers are able to do their jobs well and that clients receive a quality service, the Program has put into place a number of strategies to overcome the challenges, summarised in a table of ‘approaches that work’ (Nagel, Frendin, and Bald, 2009).

AOD Workers report that as a result of clinical supervision they are better at their job, have more direction, are more confident and happier at work and are less likely to ‘burn out’. They also comment that they feel they have support instead of feeling alone and know that there is someone to listen to them, pat them on the back and show support.

“I have been dreaming all month for supervision, because I know that after my session I will feel 110% better.

“Supervision is like a weight off my shoulders.”
### 6.1 Examples from the field

**Supervision and Support**

<table>
<thead>
<tr>
<th>Challenges to the Workforce</th>
<th>Strategies</th>
<th>In practice</th>
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</thead>
</table>
| **Governance**              | • Provide with clarity of role  
• Provide with clarity about management accountability and professional responsibility  
• Provide with regular clinical supervision and review  
• Ensure systems support and Executive and Steering Committee governance is in place  
• Provide with clarity about management accountability and professional responsibility  
• Provide with regular clinical supervision and review  
• Ensure systems support and Executive and Steering Committee governance is in place | • Roles and responsibilities are clearly documented in position description and ‘Service Partnership Agreement’  
• Primary Health Care Manager provides day-to-day management and supervision  
• Clinical Supervisor and Clinical Mentor provide specialist clinical supervision and support  
• CQI system implemented with regular meetings, regular reporting, and feedback | |
| **Sustainability**          | • Support to deliver services in both personal and practical ways:  
  o Professional development  
  o Peer support  
  o Information sharing  
  o Advocacy as a group  
  o A career structure  
  o Travel and accommodation support  
• Facilitate and promote networking and developing personal and professional relationships | • Education and Training Officer conducts training needs analysis; AOD workers are linked with appropriate training through relevant organizations  
• Training is on-going through regular teleconferences and access to educational opportunities  
• Workers are members of the PHC multidisciplinary team, with workspace and equipment  
• Workers wear a uniform identifying them as AOD workers  
• Two forums a year are held for professional development and peer support, fully subsidized  
• There is a Leadership Group of long term workers  
• An hour long teleconference is held every two weeks for all workers to discuss issues, achievements and have education  
• Clinical Supervisor visits on-site for clinical supervision, professional development and support  
• There is a dedicated website to support the orientation and workforce development of AOD workers | |
| **Implementation of best practice model** | • Provide with culturally and contextually adapted tools and resources to support best practice in service delivery and community development:  
  o Assessment and care planning tools  
  o Educational resources  
  o Guidance with respect to community development principles  
  o Data collection tools  
  o Information systems to support planning and decision making  
• Practise continuous quality improvement (CQI) | • Toolkit was developed over 18 months based on research results of the Australian Integrated Mental Health Initiative (AIMhi) in the NT  
• AOD workers are trained in use of tools  
• Tools are evaluated and refined through consultation with AOD workers; new tools are developed in response to need  
• Library of education resources are available  
• Data collection tools to reflect best practice are being developed  
• AOD workers are trained in use of data collection and audit tools  
• Audits, focus groups and interviews are conducted yearly  
• Analysis of data, feedback and action plan for improvement are developed yearly | |

**Summary of approaches that work**

- Provide with clarity of role
- Provide with clarity about management accountability and professional responsibility
- Provide with regular clinical supervision and review
- Ensure systems support and Executive and Steering Committee governance is in place
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What works well?

- Doing a thorough orientation to what clinical supervision is and is not. The clinical supervision process is strengths-based, focuses on the wellbeing of the AOD Worker and is conducted face-to-face by an external clinical supervisor. The AOD Worker signs a ‘Yarning about Work’ contract with regard to his/her role and responsibilities in relation to supervision.

- Conducting clinical supervision and support as ‘Yarning about Work’. During the session, the clinical supervisor and worker use the ‘Yarning about Work’ resource to document the discussion. It belongs to the worker and can be referred to by the worker and at following supervision sessions.

- Developing a policy about clinical supervision and identifying the responsibilities of the PHC Service Manager and the Remote AOD Program with regard to supervision and support. The Partners agree to them by signing the ‘Service Partnership Agreement’. Whenever an issue arises, the Partners can go to the Agreement to clarify and discuss roles and responsibilities.

- Having highly skilled AOD staff in the Program Support Unit (PSU), committed to the Program for the long-term. To create an enabling work environment, supportive of the Remote AOD Workforce Program, PSU staff need to develop on-going relationships with the PHC Centre Managers, staff, AOD Workers and visiting services. It takes time to understand the community context, embed the Program within an established PHC Service, gain the trust of the staff and ensure the Program’s sustainability.

What does not work so well?

- AOD Workers not having their Clinical Supervisor able to visit for a face-to-face session every month. Technology helps overcome the tyranny of distance to a certain extent. The Clinical Supervisor encourages AOD Workers to call the PSU if they are having any issues. However she is aware that some AOD Workers, especially new workers, may not feel confident enough to call. She is also aware that it takes time to develop a relationship and trust, best done through face-to-face interactions.

- The high level of support and the time it takes to embed AOD Workers into PHC teams, especially if there is high turnover of staff within the PHC Service. New PHC staff may not understand the role and responsibilities of AOD Workers nor know how to supervise their day-to-day work and support them, both personally and professionally. It requires continually engaging with Managers and staff, explaining what the Program is about, the Partners’ roles and responsibilities and ways to provide a safe and enabling work environment.
What next?

We recognise the challenging nature of the work and the stressful situations that PHC staff encounter. We understand the importance of all staff feeling valued and supported so they, in turn, can support each other as a team. Additional funding has made it possible to employ a number of new PSU staff to strengthen support for the whole PHC service. Structurally, the Program is now located in Primary Health Care Services, under Central Australia Health Service, with a Territory-wide role. Plans to grow the Program include:

- Strengthening clinical supervision and support by
  1. ensuring a gender balance by having a female and male Clinical Supervisor and Mentor
  2. focusing on reflective practice as a learned skill and
  3. exploring with AOD Workers how to fulfill their cultural obligations, given their clinical and community development responsibilities.

- Strengthening orientation to the Program by undertaking more site visits and following-up with additional support visits.

- Exploring opportunities to work with other Programs whose staff visit or live in communities on where AOD fits in their work and how they might provide support to AOD Workers and other PHC staff.

- Promoting formal supervision and support for all PHC staff to ensure a quality service and an enabling and supportive environment for all staff.

What AOD Workers have said about the value of supervision and support for them and the work it enables them to do:

“This team is the magic. People say the most wonderful things about us, as a team. We encourage and support each other.”

“To have a support network like this is invaluable. I’ve never felt more supported in my life. I could do this job for four to five years.”

“It doesn’t matter what part of the country in the NT you’re from, we all come together as one family.”

“Organisations and services should study what this Workforce is doing and how we are making a difference in each of the communities. We are all different, don’t expect us to be the same. Go, listen, look at this drug and alcohol team.”

Reference

Nagel, T, Frendin, J and Bald, J (August 2009). Remote Alcohol and Other Drugs Workforce Program Interim Report, draft paper for consultation, presented to Working Group, available upon request.

Based on information and documentation provided by Jennifer Frendin, Program Manager and Lauren Buckley, Clinical Supervisor, Remote Alcohol and Other Drugs Workforce Program, NT Department of Health. The Program acknowledges the work of the Menzies School of Health Research Aboriginal and Islander Mental Health Initiative (AlMHi) [Stay Strong Plan] 2010. More information about the NT Alcohol and Other Drugs Workforce Program and Program resources are available at the Program’s website: www.remoteaod.com.au