Routledge
Taylor & Francis Group

Advances in Mental Health
Promotion, Prevention and Early Intervention

ISSN: 1838-7357 (Print) 1837-4905 (Online) Journal homepage: http://www.tandfonline.com/loi/ramh20

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**To cite this article:** Xenia Girdler, Jocelyn Dhu & Anton Isaacs (2017): Delivering a diploma of community services (alcohol and other drugs and mental health) in the remote town of Katherine (NT): a case study, Advances in Mental Health, DOI: 10.1080/18387357.2017.1410437

**To link to this article:** https://doi.org/10.1080/18387357.2017.1410437

Published online: 29 Nov 2017.

ADVANCES IN MENTAL HEALTH, 2017
https://doi.org/10.1080/18387357.2017.1410437



# Delivering a diploma of community services (alcohol and other drugs and mental health) in the remote town of Katherine (NT): a case study

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**ABSTRACT**

**Objective:** To describe the design and implementation of a Diploma of Community Services in Katherine (NT) by RMIT University in collaboration with Sunrise Health Service Aboriginal Corporation (SHS).

**Method**: This is a descriptive case study of how, in response to a need, a city-based Diploma of Community Services (Alcohol and other Drugs and Mental Health) was modified and delivered in the remote region of Katherine in the Northern Territory. The key aspects included organisational agreements, understanding local needs and realities, collaborative development of course design, overcoming funding shortfalls, incorporating two-way learning, managing with sparse resources, and building a conducive learning environment.

**Results:** Of the 24 students who completed the course in the first two iterations of the program, 91% received their Diploma. Workshops conducted as part of the course enabled students to develop cross-agency and cross-sector connections as well as professional collaborations. After graduation, a number of students successfully applied for higher paying positions within their own or alternative services whilst others decided to go onto further study. The program has since been delivered across the NT in Alice Springs, Tennant Creek, Katherine and the remote community of Ngukurr.

**Discussion:** The lessons learnt from this endeavour could be utilised by other remote area health services and city based training organisations to design and deliver courses in remote areas of Australia.

**ARTICLE HISTORY**
Received 2 June 2017
Accepted 23 November 2017

**KEYWORDS**
Vocational education; remote education; indigenous workforce development; social and emotional well being



## Introduction

Australians living in remote areas tend to have lower life expectancy, higher rates of disease and injury and poor access to health services (Australian Institute of Health and Welfare, 2016). There are also several challenges to attracting and retaining health workers in these areas (Buykx, Humphreys, Wakerman, & Pashen, 2010). Since most of the health workforce in remote areas have relocated from elsewhere, suggested

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recruitment and retention strategies focus on improving conditions for them (Buykx et al., 2010). Furthermore, service delivery in remote areas of Australia is very different from that of metropolitan areas and is challenged by several factors such as long distances to travel, low population density, difficult climatic conditions (particularly during the prolonged wet season) and issues relating to respecting local Aboriginal culture and traditions (Battye & McTaggart, 2003).Health workers from non-remote settings might find these conditions challenging in the long run.

Community service workers in the Northern Territory (NT) support clients with co-existing social and emotional wellbeing (SEWB) issues and chronic disease at levels far exceeding national averages (Northern Territory PHN, 2016) These challenges require workers to be multi-skilled, highly competent practitioners. Yet a tyranny of distance contributes to a lack of local training and education options. Most training options for community service workers are based on 'by-distance' learning models reliant upon generic, unit specific workbooks. This approach is context-free, highly repetitive, precludes holistic outcomes and fails to deliver specialised skilled workers (Hager, 1995; Roche, Kostadinov, & White, 2014). Remote areas such as those in the NT continue to face difficulties in building a skilled workforce (Gwynne & Lincoln, 2016; West, West, West, & Usher, 2011). The purpose of this paper is to describe a case study regarding how a metropolitan based Diploma of Community Services was modified and delivered in the remote town of Katherine (NT). The modifications were made by RMIT University in collaboration with Sunrise Health Service Aboriginal Corporation (SHS).

## Setting and context

The Northern Territory (NT) in Australia, spans 1.421 million square kilometres. With a population of less than 300,000, it is the most sparsely populated area in Australia and hosts some of the most isolated communities in the world (Northern Territory Government, 2017). Thirty percent of the NT population are Aboriginal compared to the national figure of just over 3% (Australian Indigenous HealthInfoNet, 2017). Katherine is the third largest town in the NT and lies 320 km south of Darwin. It has a population of just over 11,000, 52% of whom identify as Aboriginal and/or Torres Strait Islander (Katherine Town Council, 2017).

The Greater Katherine Region extends between the state borders of Western Australia and Queensland (Katherine Town Council, 2017). Although Katherine Township was established in 1926 it has a long pre-colonialist history and was the traditional meeting place for the three Aboriginal tribes – Dagoman, Jawoyn and Wardaman peoples (Godinymayin Yijard Rivers Arts and Culture Centre, 2013). SHS Aboriginal Corporation is a community controlled health service in Katherine with a catchment stretching 750,000 square kilometres covering 16 remote communities in East Katherine (Sunrise Health Service, 2007).

The policy underpinning the way SHS delivers services is The Sunrise Way, a Cultural Framework built on respect, understanding and commitment (The Sunrise Health Service, 2010). The Sunrise Way acknowledges the pivotal role community-based care plays. It articulates the need to provide meaningful employment and education pathways for Aboriginal and other local people so they may take control of their own SEWB, physical

health and community need. At the foundation of these ideals is workforce development and education options which are accessible and equitable. However, given SHS's remote location, this had been difficult to establish or maintain.

The Diploma of Community Services (Alcohol and Other Drugs and Mental Health) was designed to be delivered in Melbourne by RMIT University. It consisted of 19 compulsory Units of Competency and had a pre-requisite of a Certificate IV in Mental Health or Alcohol and Other Drugs or sufficient experience in the Community Services Sector (Training.gov.au, 2013). It had taken XG, [the program developer] six months to design the training and assessment strategy with the assistance of key industry representatives. The strategy was built upon clustered practice themes that reflected service delivery within urban environments.

In 2012, SHS Executive invited the program developer to design and deliver vocational qualifications to meet workforce development needs and complex case management requirements of their client base. SHS wanted staff to gain the nationally accredited dual diagnosis qualification which was not available in the NT but which was delivered in Melbourne. The training needed to acknowledge and build workforce competency and lead to improved client outcomes. Crucially, SHS needed the Diploma to be delivered face-to-face in Katherine.



## Method

### *Organisational agreements and first steps*

When SHS initially approached the program developer with plans to deliver the Diploma in Katherine, RMIT University did not have Government funding to deliver the program in the NT. Given that SHS required a face-to-face delivery model, and all program staff were based in Melbourne, a minimum number of candidates were required to enrol at a fixed fee for service (FFS) price to make the program financially viable. A Memorandum of Understanding was signed between SHS and RMIT to validate the collaboration and SHS committed to pay for eight of their staff and provide financial support, by way of a loan, to two external practitioners. The remaining students needed to be recruited from external agencies.

RMIT had no corporate profile in the Northern Territory nor Katherine and as the program developer had no local networks, it was up to the SHS Team leader of AOD [Alcohol and other Drugs] and Tobacco programs to recruit for the course. Over the period of three weeks a total of 25 candidates from agencies in and around Katherine had registered interest. On the strength of those numbers the program developer travelled to Katherine to facilitate an orientation and enrolment session. However, when the program developer arrived she discovered that many people who had registered their interest had left their jobs or failed to get agency support to undertake the program. On the day of enrolments, no one but the supported staff from SHS turned up. That afternoon the program developer cold-called every community service organisation in Katherine. Despite the interest in the program design and intended outcomes, there remained a scepticism that the program was being led by an outsider and by an organisation from 'Down South'. The NT was well accustomed to external services promising to deliver training which, when the geographic and other related complexities surfaced, were not followed

through. Nevertheless, key personnel from the services agreed to attend a re-scheduled information session for the end of that week.

### Understanding local needs and realities

In order for the qualification to meet the unique needs of workers in the NT the program had to be contextualised, to ensure vocational relevance whilst continuing to meet the prescribed critical aspects of assessment. To achieve this, the program developer met with SHS management to gain insight into service delivery realities and travelled to remote communities to establish relationships with local lead agencies, observe workers and hold discussions with community and clients. Whilst the basic steps of developing a training and assessment strategy remained the same, the program design needed to reflect the realities of remote community services work.

### Collaborative development of course design

The information session mentioned earlier became an education and collaboration opportunity for the whole region and an opportunity for the program developer to establish credibility as an educator and vocational program designer. Local stakeholders were able to understand and appreciate the integrity of the pedagogy as they contributed to the program's training and assessment strategy. Those who attended the information session consisted of senior staff and managers from lead community health services. They were able to provide industry expertise and contribute to the curriculum as well as provide input into what could support its successful delivery. Over a period of five hours, and using the design shell created for the Melbourne-based Diploma, the program developer supported them to map out and create a NT centric Diploma of Community Services (AOD and MH). The delivery and assessment of this program was relevant to the SEWB needs of people in the Katherine Region and the NT in general and reflected the practicalities of case management in geographically isolated areas.

Course content in Katherine needed to reflect the realities of remote environments. The climate, the terrain, the lack of infrastructure and resources play a significant role in how SEWB, mental health and AOD programs are delivered. Course delivery and content also needed to consider how theory could support high quality case management even when the best practice clinical governance frameworks and structures such as intake, assessment, referral pathways, supervision and peer support were not available. In addition, stakeholders indicated that the case study client developed for the NT students needed to reflect co-occurring chronic health issues and different patterns of substance abuse as well as the fact that those issues typically fell under the umbrella of SEWB rather than co-morbidity or dual diagnosis. In adopting these changes, trainers needed to respect the knowledge of the students throughout the delivery and assume a learner role that was far more than is typical in a conventional and urban classroom setting. Trainers also needed to take into account cultural safety. Accordingly, a lesson on Aboriginal culture and lore was delivered early in the course by one of the students.

There are only two seasons in the Top End of Australia. The Dry and the Wet. The Dry brings with it hundreds of thousands of tourists placing strain on essential services and

infrastructure. All travel costs, including accommodation, escalate during this time of year. In comparison, the Wet is quiet and costs are low. However access to Katherine and outlying communities during the wet can be precarious if not impossible, unless traversed by charter plane. Therefore, whilst it made economic sense to run much of the program during the wet, it was not feasible. These issues needed to be taken into account when timetabling and budgeting for the program. This also impacted upon students who needed to travel to Katherine from elsewhere. Furthermore, while in Katherine, students were accommodated in local motels or stayed with relatives – the cost of which was born by their employers or study assistance programs (for those who were eligible).

The Course was divided into two terms. The first term extended for five months from July to November. This was followed by a three month break for the wet season during the months December to February. The second term extended from March to May. Hence the course consisted of eight teaching months. A total of 16 workshop days were conducted during the course with two each month. Table 1 outlines how the Melbourne based Diploma was modified to be delivered in Katherine.



### *Incorporating two-way learning*

The trainers engaged to teach the Diploma course in the NT were from Victoria. They were respected practitioners with significant experience in dual diagnosis (mental health and AOD) and vocational learning. They were not, however, experienced working in remote Australia nor the NT. Consequently, whilst they could provide evidence based frameworks, models of practice and theoretical knowledge, it would be the students, all of whom were experienced practitioners, who would bring the practical expertise and knowledge. Students also educated trainers on how to apply a two-way learning approach in a culturally appropriate manner because whilst not all the students were Indigenous, almost 80% of their clientele were. Therefore, it was critical that the principles of two-way learning underpinned and drove the pedagogical design (Walsh, 2016). Trainers needed to recognise they were not the experts when it came to the practical and cultural application of theoretic frameworks. In this context, it would be the learners and their communities who had the most to teach.

Emphasis was placed upon the interaction between learner and trainer, with at times a reversal in the role of expert and novice. Trainers would introduce theory and frameworks whilst students provided the expertise on how this would or could be practically applied within a remote and cultural context. Trainers would also travel out to community with the program developer and SHS staff in between class times to familiarise themselves with and establish themselves in the realities of remote. As a result the learning and teaching was shared; the trainers learning much more from students and community than they would have in a more conventional and familiar classroom setting.

Workshops and assessment tasks were designed to bring together workers from a number of agencies as learners and peers who could engage in meaningful collaboration, reflection and supervision, with and of each other's practice. Through this process students could demonstrate what they knew, develop the competency required to meet national training standards and be formally recognised as an advanced dual diagnosis practitioner. The training established a support network which had not previously existed and had the potential to continue beyond the life cycle of the Diploma program.

**Table 1.** The diploma of community services as delivered in Melbourne and Katherine.

| Component of course | Diploma for Melbourne | Diploma for Katherine | Reason for modification |
|---|---|---|---|
| Course duration | 12 months (two semesters) within the academic year | 8 teaching months (September – July period) | To reduce travelling costs.<br>To void travelling during the wet season |
| Face to face Workshops | 12 workshops<br>Lasting a day each every Month from<br>9.30 am to 5.00 pm | Sixteen monthly workshops lasting two days each<br>Slightly later start and earlier finishing time.<br>One in-class day offered to students after each workshop<br>Site and community visits | To allow students to stay in town and use free time to shop, stock up on supplies and catch up with family and friends.<br>The shorter days were to accommodate for the searing heat and allow those travelling in from remote communities to avoid too much pre-dawn and post dusk driving. (Kangaroos and large unfenced cattle are often out at dusk and Water buffalos are the same colour as the road at these times of the day).<br>To allow for secondary consultation and assessment support<br>To provide students with peer reflection and supervision with trainers |
| Workshop content and development of the Training and Assessment Strategy | Undertaken over six months and in consultation with key stakeholders from AOD, mental health and dual diagnosis and representatives from peak bodies and lead agencies | Undertaken over one week. Two days in consultation with managers and senior workers of local community controlled health services, NGOs and government service providers and three days travelling to remote communities and meeting with staff and community members | To address social, political, cultural and economic complexities of environments and the clients in Katherine |
| Industry expert seminars | Additional seminars facilitated by industry experts one evening per week (3 h) over two semesters | None | Practical experience of known experts were from urban settings which was of limited value to the realities experienced by this group.<br>Cost factors prohibited extra classes being scheduled |



## *Managing with sparse resources*

The University had no footprint in the NT nor ties with other institutions. Therefore all of the usual resources (classrooms, IT equipment, Library) afforded to program delivery in Melbourne were not available. Workshops were held at the Katherine Business and Training Centre (previously the local high school), which offered no administration support, no IT equipment nor internet access. It had been identified during the planning phase itself that many workers did not have access to computers after hours and that the internet was unreliable in town and often non-existent out on community. The training team therefore became a mobile University bringing all their own IT equipment – laptops, data projectors, 4G dongles and learning and teaching resources in hard copy from Melbourne.

### *Building a conducive learning environment*

The initial two days of the Diploma program were designed to create a sense of connection for the students, the program developer and trainers. The curriculum took a back seat because it was crucial to talk and walk learners through competency based experiential learning. Some students were venturing back into a classroom after a long period of absence. For others, their previous experience with education had not been positive. A number of students undertaking the Diploma had been attempting to complete the by-distance Certificate IV in AOD for many years and felt their inability to complete the qualification was a reflection on their ability as students. Consequently those initial two days were a chance and opportunity to allay fears, boost confidence, and build rapport.

Another important factor of the course design was a small team of trainers. This consistency and continuity of trainers resulted in opportunities for secondary consultation within the workshops. Given the isolation many workers in the NT operate within, time was allocated during and after workshops to engage in peer reflection and case conferencing. Challenges with clients and other practice issues could be discussed in-class, thereby becoming a quasi peer-supervision model.

## Results

There were some tangible outcomes for the students and the organisations involved. Of the 16 students who completed the first iteration of the Diploma program (2012–2013), five withdrew either due to financial reasons or because they moved out of the territory. Eleven students completed the course resulting in nine graduating with a Diploma. Following the successful completion of the 2012–2013 Diploma program, the NT Government supported RMIT (through Labour Market funding) to run a second Diploma program. This funding enabled RMIT to offer the program without enrolment fees. As a result, in the second iteration thirteen workers enrolled and twelve (92%) completed. These workers were from a wide range of services and from areas as far away as Alice Springs and Tennant Creek and the remote community of Bulman. See Table 2.

In addition, the resulting industry endorsement and worker feedback enabled the inclusion of delivering the Certificate IV in Alcohol and Other Drug work. As opposed to the Diploma (which was specifically designed for the experienced mental health or AOD and other complex care workers), the Certificate IV is a program aimed at upskilling new workers or pre-vocational learners and is recognised as the minimum requirement for people wanting to work in the Alcohol and Other drug sector.

Through networking and relationship building there were more local services in Katherine wanting to be involved and a strong relationship with an NT wide workforce support Unit meant AOD and mental health workers could also access study support through the program. There were some delivery and assessment alterations as well making the program even more reflective of the on-the-ground reality. A peer mentor and reflective practice element was incorporated into the face-to-face learning component which not only met the program's critical aspects of assessment (as prescribed in the national training package) but provided workers valuable peer supervision with other workers from across the NT. An extra day was also added every month to conduct site visits and assist students with their assessment tasks.

**Table 2.** Characteristics of students who attended the diploma course in Katherine.

| 1st iteration of the diploma course (fee for service and user choice funded) | | | | | |
|---|---|---|---|---|---|
| No. | Substantive role | Age | Sex | Residence | Completion status |
| 1 | Youth officer (NT Police) | 30–40 | M | Local | YES |
| 2 | Physical Activities Officer | 20–30 | F | Local | Partial[a] |
| 3 | Police Officer | 30–35 | F | local | YES |
| 4 | Youth Worker | 30–35 | F | Local | YES |
| 5 | Senior Aboriginal Kinship Care worker | 30–40 | M | local | YES |
| 6 | AOD and Tobacco manager | 50–60 | M | Local | YES |
| 7 | Training Manager SHS | 50–60 | M | Local | YES |
| 8 | Senior worker Population Health | 50–60 | F | Local | YES |
| 9 | Child and Family worker | 40–50 | F | Local | No – left NT[b] |
| 10 | Intensive Family Support | 40–50 | F | Local | YES |
| 11 | AOD Worker | 40–50 | F | 317 km away | No – left NT[b] |
| 12 | Youth Worker | 20–25 | F | local | YES |
| 13 | Baptist Minister | 40–50 | M | local | Partial[a] |
| 14 | SEWB worker | 30–40 | M | Local | No – left NT[b] |
| 15 | AOD worker | 40–50 | F | local | No – Organisation withdrew financial support[b] |
| 16 | AOD worker | 40–50 | F | local | No – Organisation withdrew financial support[b] |
| **2nd iteration of the diploma course (labour market funding)** | | | | | |
| 17 | AOD worker | 30–40 | F | 1,182 km away | YES |
| 18 | Board Member | 50–60 | F | Local | YES |
| 19 | AOD worker | 60+ | M | 675 km away | YES |
| 20 | AOD worker | 40–50 | M | Local | YES |
| 21 | AOD worker | 30–40 | F | 1,182 km away | YES |
| 22 | AOD worker | 20–30 | M | 308 km away | YES |
| 23 | RJCP[c] worker | 40–50 | F | Local | YES |
| 24 | AOD worker | 40–50 | M | Local | YES |
| 25 | AOD worker | 20–30 | F | Local | YES |
| 26 | Social Worker | 30–40 | M | Local | YES |
| 27 | AOD worker | 40–50 | M | Local | YES |
| 28 | AOD worker | 40–50 | F | 675 km away | YES |
| 29 | AOD facility manager | 40–50 | M | Local | Partial[a] |

[a]Students who completed the course but did not receive their diploma because they did not achieve all competencies.
[b]Students who withdrew from the course after commencing.
[c]Remote jobs and communities program.



Workshops conducted as part of the course enabled students to develop cross-agency, and cross-sector connections as well as professional collaborations. Students also started to expand upon newly acquired skills and deliver complex case management by considering options for referral and continuity of care with other services. A formal graduation was conducted with the Dean of the School of Global, Urban and Social Studies in attendance. For many graduating students it was the first time anyone in their family had completed a further education program. After graduation, a number of students successfully applied for higher paying positions within their own or alternative services whilst others decided to go onto further study. Professional development opportunities also became available for two Aboriginal students from the second iteration of the program to present with the program developer at an international Indigenous Research Conference.

Having staff with formal qualifications enabled service organisations to meet Accreditation and Funding Service Agreements, thereby securing ongoing and future funding. The endeavour of setting the Diploma program up in Katherine won Outstanding Training Initiative of the year in 2012 – a RMIT University award for excellence in a vocational training initiative. By 2015 the University was receiving sufficient funding from the NT

government to run the Diploma of mental health and AOD and the Certificate IV in AOD programs across the NT in Alice Springs, Tennant Creek, Katherine and the remote community of Ngukurr. In 2016, the Diploma was successfully delivered in Alice Springs and Tennent Creek. Completion rates continued to remain above 85% and RMIT had established itself in the NT Mental health and AOD learning space.

## Discussion

This was an unprecedented initiative that was undertaken due to an expressed need of the local health service for quality training and qualifications for community service workers in Katherine. Although the process was in many ways determined by trial and error, the end result was very encouraging and the effort had tangible outcomes. The first iteration of the program was delivered through support from Sunrise Health Service. The workers were sponsored by Sunrise and vetted by Sunrise. As it was a fee for service program, workers from other organisations had no financial support and this placed extra strain on their ability to complete. Students who enrolled but did not complete (withdrew) the program belonged to one of two categories. Either their workplace withdrew support for their course or they left their position and moved either into a job role outside the sector or interstate. There was one student in the second group who left her role and moved to another AOD mental health role in QLD. Through negotiation with her new employer it was possible to support her to continue with her studies and complete the program. Students who remained in the program but did not gain the full qualification either did not submit their work to be assessed or their work did not meet the competency requirements. In competency based programs students are able to resubmit work for reassessment. However all programs have a completion date. Students who fail to demonstrate competency by the completion date would have to re-enrol and this carries costs.

There are indeed some important lessons to learn from this endeavour. First, there is an unmet need for specialised training of local community service workers in remote areas of NT. Second, this specialised training needs to be designed and implemented in collaboration with local service and community stakeholders. Third, it is important to ensure that adequate funding arrangements are in place. The final lesson is that city based trainers need to have the humility to learn from the vast local knowledge and experience of their students. Local circumstances including significant geographical distances, unique cultural differences, and seasonal variations are important considerations when planning and delivering a course in the NT. It is also imperative to ensure that the design reflected local expertise and experience and that local service managers and executives vouch for and believe in its quality and integrity. Without their support, it would be difficult to recruit students.

Furthermore, it was necessary for at least one trainer in the team to develop strong relationships with agencies and students to allow them to consistently seek feedback and help. In this case, the program developer built relationships at the outset and continued to meet and spend time in communities. Active participation of the program developer remained key to continuity, consistency and connection for students, organisations and community stakeholders. The involvement of the program developer drove the project in the first place. Replication of this model is possible with collaborations between remote area health services and city based course providers in modifying courses

to suit local needs and situations. State and Territory governments also need to support these endeavours by providing adequate funding steams.

## Conclusion

This case study shows that with political will, unwavering optimism and shared vision it is possible to deliver a course designed by a city university in a remote area to help build a skilled local workforce. The lessons learnt from this endeavour could be utilised by other city based training organisations to design and deliver courses in remote areas of Australia.

## Acknowledgements

The authors would like to thank Professor David Hayward of RMIT University and Stacey Campton from Ngarara Willim Centre for Aboriginal and Torres Strait Islander peoples RMIT University, for proof reading the manuscript. Dr Ahmed Latif, Graham Castine, Dale Campbell and Geoffrey Lohmeyer from Sunrise Health Service. Pamela Acres from Wurli Wurlinjang Workforce Support Unit. Michelle Kudell and Miranda Halliday from Alcohol and Drug Associations NT. Lauren Buckley from Remote AOD workforce Support. Fiona McManus from Department of Business, NT Government. Stuart Henry from World Plumbing Council. William Tune from Victorian Dual Diagnosis Initiative. Kevin Moore from Ngarara Willim Centre for Aboriginal and Torres Strait Islander peoples RMIT University. Christine Robertson, Dr Helen Smith, Dr Elizabeth Kath, Anne Marie Carroll, David McElgunn, Daniel Teague, Anthony Graham and Spiros Soulis from RMIT University. Maggie Toko and Mauro Thon Guidici for their help and support with undertaking this program.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Funding

This work was supported by the NT Government User Choice and Market Place schemes.

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