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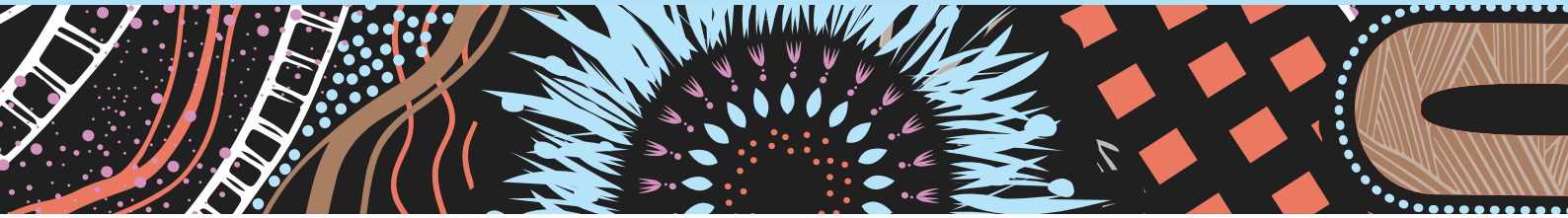
INDIGENOUS
Mental Health and Suicide Prevention
Clearinghouse

Improving mental health outcomes with an Indigenous mental health workforce

Summary paper



This paper is a summary of the *Improving Indigenous mental health outcomes with an Indigenous mental health workforce* publication by Penney Upton, Linda Ford, Ruth Wallace, Sarah Jackson, Jenna Richard and Dominic Upton. This publication was commissioned by and published on the Australian Institute of Health and Welfare Indigenous Mental Health and Suicide Prevention Clearinghouse. It can be accessed online at <www.indigenousmhspc.gov.au>.

Some people may find the content of this report confronting or distressing. If you are affected in this way, please contact **13YARN (13 92 76)**, **Lifeline (13 11 14)** or **Beyond Blue (1300 22 4636)**.

Key findings

Aboriginal and Torres Strait Islander people (Indigenous Australians) hold less than 2% of jobs in the health sector. Small numbers of Indigenous Australians in the mental health workforce are a barrier to the use of these services by Indigenous Australians. In 2014–15, almost a quarter (23%) of Indigenous Australians experienced difficulties accessing health services.

Systemic changes are needed in education and health services to embed cultural competency in professional training and the workplace. Such changes will increase the number and retention of Indigenous Australians in the mental health workforce. Factors to consider:

- Cultural safety improves when care is provided by an Indigenous mental health worker who has an intrinsic understanding of Indigenous cultural beliefs and ways of knowing.
- In mainstream services, cultural competency training is needed for non-Indigenous health workers to ensure the cultural safety of these health providers. This should be actively monitored.
- Cultural safety can also be improved by offering interpreter services, and culturally relevant services such as traditional healing and bush medicine. When setting visitor numbers in hospitals, consider the central role of family.
- Build Indigenous student numbers by embedding cultural safety in undergraduate curriculums. Courses should offer flexible teaching delivery, support connection with peers, promote feelings of ownership over the course to empower students.

- Educate all health students with cultural respect and a holistic view of mental health.
- Indigenous leadership and community control of the mental health workforce is important, with self-determination ensuring mental health responses are culturally safe and encapsulate Indigenous social and emotional wellbeing, rather than clinical treatments alone.
- Partnerships between Aboriginal Community Controlled Health Services and mainstream mental health services are important and support self-determination. They also:
  - promote sharing of knowledge, which increases cultural awareness for staff in mainstream mental health services
  - aid pooling of resources to increase clinical expertise and capability
  - facilitate greater engagement by the mainstream service with the Indigenous community, which builds trust
  - support skill development and career progression pathways for Aboriginal health workers that are flexible and that support their goals.
- Peer support and mentorship programs for Indigenous health workers are known to improve job satisfaction, retention, and reduce stress and emotional burden for these workers.
- Support and encouragement are needed to ensure greater representation of Indigenous Australians in professional bodies.

What we know

There are high rates of psychological distress in the Aboriginal and Torres Strait Islander community. Psychological distress is an indicator of poor mental health, such as stress, anxiety or depression. Suicide rates are also high and contribute to the gap in mortality and life expectancy between Indigenous and non-Indigenous Australians.

- Studies have shown there is a disparity in mental health outcomes, social determinants and access to services between Indigenous and non-Indigenous Australians.
- Currently the small numbers of Indigenous Australians in the mental health workforce are regarded as a barrier to their use of mental health services.
- There are challenges recruiting and retaining Aboriginal and Torres Strait Islander mental health staff. A small number of, often localised, programs have been implemented to attract and support Indigenous Australians to a career in mental health.
- Systemic changes at the health service and educational level are needed to embed cultural competency in the workplace and professional training.

Mental health status of Indigenous Australians

Indigenous Australians have a holistic understanding of health encompassed by the concept of social and emotional wellbeing (SEWB). Wellbeing is not an individualistic concept. For Indigenous Australians, wellbeing is tied to spiritual and cultural fulfilment, including a strong connection to Country. It is also intertwined with family and community (Dudgeon et al. 2014). Mental health is embedded in this holistic understanding of health.

- Around 3 in 10 (31%) Indigenous Australians report high or very high levels of psychological distress, with females more affected (35%) than males (26%). This is more than double the rate of that experienced in the general Australian population (AIHW and NIAA 2020).
- Suicide is in the top 5 causes of death for Indigenous Australians, with suicide rates almost double that of the general population (ABS 2019). For young Aboriginal males suicide was the second most common cause of death in 2018 (ABS 2019).

Access to services

Primary health services are available through Indigenous specific primary health care services, the majority of which are provided by Aboriginal Community Controlled Health Services (ACCHS) and mainstream primary health care services. The *National Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing*, which recognises the Indigenous holistic view of health (Dudgeon et al. 2014), underpins health service provision in many ACCHS. However, service access issues include:

- More than two-thirds of ACCHS (68%) report SEWB to be a gap in their service delivery offerings (AIHW 2019b).
- Accessing mental health services presents challenges for Indigenous Australians. For example, in 2014–15, 23% of Indigenous Australians experienced difficulties in accessing health services (ABS 2016).
- For people living in remote and very remote areas, mental health and wellbeing supports are often even more limited, with substantially lower ratios of psychiatrists per 100,000 population in these areas, compared with the Australian metropolitan population. Psychiatrists are less willing to take up roles in these remote areas (RANZCP 2019).
- In 2014–2015, Indigenous Australians accessed psychiatrists at almost half the rate of non- Indigenous Australians (52 per 1,000, compared to a rate of 97 per 1,000 for non-Indigenous Australians) (AIHW 2019a). A study by Sveticic et al. (2012), found the likelihood of an Indigenous person having accessed support from any mental health service in the 3 months preceding their death by suicide was half that of non-Indigenous Australians.

For many Indigenous Australians there is a lack of trust in non-Indigenous mainstream health services, in part associated with past political actions, such as the forced removal of children from Indigenous families, and also associated with systemic racism and discrimination (Canuto et al. 2018; HREOC 1997; Trueman 2013). In some cases, less culturally competent practices are barriers, these include maximum visitor rules to hospitals which fail to consider the central role of family; and the failure to use interpreters where language barriers exist (Durey et al. 2012).

Cultural safety and cultural competence in service delivery

Aboriginal and Torres Strait Islander people have more trust in mental health services delivered by Indigenous mental health workers and professionals, who can deliver culturally safe and relevant mental health services, with a holistic social and emotional wellbeing perspective (see Box 1).

Box 1: Cultural safety and cultural competency – what are they?

Cultural safety refers to the provision of an environment that is physically, spiritually, socially and emotionally safe (Williams 1999). Cultural safety is the subjective experience of Indigenous Australians as employees or as people receiving mental health care. In measuring cultural safety, it is therefore necessary to seek feedback from Indigenous employees and clients (AIHW 2019a). It is important for Indigenous Australians in education, as employees or as people receiving mental health care.

In mental health services, cultural safety improves when care is provided by an Indigenous mental health worker who has an intrinsic understanding of Indigenous cultural beliefs and ways of knowing (Aboriginal Resource and Development Services Corporation 2015).

Cultural competency is the ability to understand, communicate and interact effectively across cultures. Culturally safe mental health services need practitioners who are culturally competent.

With around half of Indigenous Australians accessing ACCHS for any health care needs (AIHW 2019b), the other half are likely to be largely reliant on mainstream services, underscoring the importance of cultural competency in these services. Service options are even more limited where specialist clinical treatment is needed, particularly in remote areas.

While cultural orientation occurs for non-Indigenous staff in 90% of Indigenous specific primary health care organisations, only 57% define this as a staff competency and actively monitor it (AHMAC 2017). Information on the delivery of cultural competency training in mainstream health services is limited. Where programs to develop cultural competency are introduced, they need to be developed with Indigenous staff members and community.

Other important offerings to support cultural safety, such as the availability of interpreter services in primary health care services, are limited. Interpreters are available in 40% of services, although the demand for interpreters more broadly is not clear. The incorporation of other culturally relevant services, such as traditional healing and bush medicine into service-delivery models, occurs in less than a third of services (AIHW 2019a).

Workforce issues

Indigenous Australians represent a very small percentage of the mental health workforce and hold less than 2% of jobs in the entire health sector (Lai et al. 2018). This shortage limits access to Indigenous health workers and is a key barrier to Indigenous Australians, who might prefer to engage with Indigenous mental health workers and professionals (Ware 2013). Other issues include:

- Just under half (46%) of all staff employed by ACCHS identify as Indigenous (AIHW 2019a). Almost three-quarters (71%) of ACCHS experience challenges in recruiting, as well as providing appropriate training and support to Indigenous Australian staff (AIHW 2019a).
- Staff retention and burnout have also been described as an issue (Deroy and Schütze 2019).
- Dropout rates for Indigenous students taking health courses in both tertiary and vocational education and training programs are also high, with cultural obligations one factor affecting educational engagement (Taylor et al. 2019). Despite growth in student numbers in recent years, Australian Indigenous medical graduates made up only 1.4% of all medical students graduating in Australia in 2017 (Medical Deans 2021). Peer mentorship or liaison officers, as provided by the Australian Indigenous Doctors' Association, can support medical students and doctors.

Relevant policies, programs and initiatives

Policies

The Australian Government and the states and territories have developed strategic and policy frameworks to support better mental health and suicide prevention outcomes for Indigenous Australians. These frameworks are designed to strengthen the mental health workforce and include plans to develop workforce targets and support the development of a culturally responsible health workforce.

Primary Health Networks (PHN) are expected to engage in workforce development and address service and workforce gaps (PHN Advisory Panel on Mental Health 2018). PHNs have been provided guidance on the commissioning of mental health services for Indigenous Australians (Department of Health 2019), together with strong advice to co-design services in partnership with Indigenous Australian leadership and Aboriginal Community Controlled Health Organisations (ACCHOs).

More detail on the Australian Government, state and territory frameworks and strategies is available in Chapter 4 and Appendix A of the full publication.

Programs and initiatives

Twelve national, state or territory programs or initiatives were reviewed, of which 11 related to improving the number and skills of Indigenous health workers or improving the cultural safety for Indigenous workers and people. The other program – Access to Allied Psychological Services – provides mental health support to Indigenous Australians who do not engage with ACCHS. Three scholarships for Indigenous Australians in health or psychology were also identified alongside the program information. Table 1 outlines programs and available evaluations.

Table 1: Program descriptions and evaluation information

Name and brief description	Location/ Indigenous specific?	Evaluation
Northern Territory Aboriginal Health Academy A traineeship to get Indigenous high school students into allied health careers	Northern Territory, New South Wales; Queensland, Australian Capital Territory Indigenous specific – no	None available, in progress
High School to Health Careers Program (Northern Territory) Program to promote careers in health to rural and remote schoolchildren (visits by students enrolled)	Northern Territory Indigenous specific – no	None available publicly; Feedback from students has been collected.
Djirruwang Program Facilitates a Bachelor of Health Science (Mental Health) for Indigenous Australians	New South Wales, Victoria, Western Australia, Queensland, the Australian Capital Territory Indigenous specific – yes	Cosgrave et al. (2017); ARTD Consultants et al. (2013); Rigby et al. (2010); Grosvenor et al. (2006); CBPATSISP (2020).
Expanded Workforce – Aboriginal social and emotional wellbeing, mental health and alcohol and drug treatment (Victoria) Expanded Indigenous Australian mental health and drug and alcohol workforce through funding for Indigenous specific positions in Victoria	Victoria Indigenous specific – yes	None available; Information on outcomes included in Victoria's mental health services annual report 2018–19 annual report (Victorian Government 2019).
SEWB workforce support unit Queensland Aboriginal and Islander Health Council (QAIHC) Social and Emotional Wellbeing Workforce Development Support Unit. Professional development opportunities for Social and Emotional Wellbeing workforce in Queensland	Queensland Indigenous specific – yes	None available publicly
SEWB workforce support unit Social and Emotional Wellbeing Workforce Support Unit Program. Professional development and other assistance for Indigenous workers in Victoria	Victoria Indigenous specific – yes	None available publicly
SEWB workforce support unit Workforce Development Program and Rural Aboriginal Health Worker Program (South Australia). Workforce development program operated by Nunkuwarrin Yunti, including support, networking and advocacy, for Indigenous health workers across South Australia	South Australia Indigenous specific – yes	None available publicly
SEWB workforce support unit Yorgum Aboriginal Corporation – Workforce Support Unit. Support social and emotional wellbeing of workers within Perth and surrounding area	Western Australia Indigenous specific – yes	None available publicly

Name and brief description	Location/ Indigenous specific?	Evaluation
Naanggabun Yarning: Aboriginal peer reflection and supervision model and framework Provides culturally safe supervision and training for Indigenous Australian health workers in Victoria	Victoria Indigenous specific – yes, parts of program	Nexus (2015)
RANZCP initiatives To encourage and support Indigenous Australian into psychiatry profession	Australia and New Zealand Indigenous specific – no	None available publicly
IAHA Mentoring Program Supports Indigenous health workers with their professional development journey	National Indigenous specific – yes	None available publicly; Positive feedback from participants has been collated
Access to Allied Psychological Services (ATAPS) Program Provides mental health supports to Indigenous Australians who are unable or have chosen not to engage with ACCHS	National Indigenous specific – no	Reifels et al. (2018)
Indigenous Psychology Scholarship Program		None available publicly
Indigenous Practitioner Scholarships		None available publicly
Puggy Hunter Memorial Scholarship		None available; Positive feedback from participants has been collated

Notable elements of these programs were as follows:

- Seven of the cited programs are locally focused, that is, operating within a single state or territory only.
- Eight of the cited programs were Indigenous specific in their focus, or primarily so. They include initiatives to encourage Indigenous students to take up careers in health or allied health, including in rural and remote areas.
- Several of the programs incorporate mentoring by Indigenous Australian peers for students and have an emphasis on cultural safety in their delivery of training.
- Workforce or professional development were also features of the programs, alongside support for Indigenous health workers.
- The initiatives of Royal Australian and New Zealand College of Psychiatrists (RANZCP) encourage and support the entry and retention of Indigenous Australians in the profession, such as via the provision of financial support through grants. They have also adapted their framework to incorporate Indigenous competency when working with Indigenous clients.
- The Djirruwang Program, which facilitates a Bachelor of Health Science (Mental Health) for Indigenous Australians, is a long-standing program with a strong focus on building the Indigenous Australian mental health workforce that has been replicated across several jurisdictions (see Box 2).

What works

Two central themes emerge:

- The importance of the Indigenous mental health workforce and Indigenous-led mental health services for providing a culturally safe environment for Aboriginal and Torres Strait Islander people.
- Mainstream services used by Indigenous Australians, need to be culturally safe, with practitioners who are culturally competent.

Improving cultural safety requires systemic changes in both the education and workforce sectors, as follows:

- Cultural competence and trauma-informed practice need to be implemented as key performance indicators in workplaces and curriculums. This ensures effective suicide prevention and intervention work (Dudgeon et al. 2016), but it is also relevant to more generic aspects of mental health work.
- Cultural safety should be incorporated into undergraduate curriculums. This will lead to more Indigenous Australians entering health education programs (Kurtz et al. 2018).
- The Australian Government Aboriginal and Torres Strait Islander Health Curriculum Framework includes an aim to 'embed mandatory cultural competency curriculums, including an understanding of the role of the Aboriginal and Torres Strait Islander Health Worker' (Department of Health 2014).
- Such developments must be made in partnership with Indigenous Australians.

Box 2: Djirruwang Program

In partnership with the NSW Government, Charles Sturt University facilitates the Djirruwang Program. It commenced in 1994 with 5 students (Brideson and Kanowski 2004), leading the way in offering clinical mental health training at a tertiary level to Indigenous Australian students. Since its commencement, it has developed into a degree program and expanded into 5 jurisdictions. Students study a Bachelor of Health Science (Mental Health), but they can exit after completing the Diploma, Associate Degree or full Bachelor program.

The program aims to make mental health qualifications at a tertiary level for Indigenous Australians more accessible. It also aims to support the expansion of a qualified Indigenous mental health workforce across the country (Grosvenor et al. 2006). In 2019, more than 250 students graduated from the program and another 77 new enrolments were received (CBPATSISP 2020).

The program proves the value of educating students with cultural respect and a holistic view of mental health. Strengths in the Djirruwang Program noted by students include its flexible teaching delivery, connection to peers, ownership of the course and feelings of empowerment. All are noted as critical supports to study and to pursuing a mental health career. Stakeholders held in high regard the Program's contribution to cultural awareness in health services.

Principles for strengthening the Indigenous mental health workforce

Three driving principles will increase and strengthen the Indigenous mental health workforce, and improve mental health outcomes for Indigenous Australians:

- An expanded and strengthened Indigenous mental health workforce.
- Indigenous leadership and control of this mental health workforce.
- Mental health services working together.

Expanded and strengthened workforce

An expanded and strengthened Indigenous mental health workforce will improve the cultural safety experienced by clients. In turn it supports increased access to mental health services, which address the mental health needs of Indigenous Australians from a wider SEWB perspective. Cultural safety will improve when these needs are understood (AHMAC 2016) and truly underpin service delivery. Suicide prevention efforts should also embody the SEWB conceptualisation of mental health, which can be best provided by ACCHS (Central Australian Aboriginal Congress 2019).

Aboriginal and Torres Strait Islander people in the mental health workforce are not well represented in professional bodies. Several of the relevant professional bodies have declared an intent to increase recruitment and retention of Indigenous Australians into their professions and have recognised the importance of this to improvements in Indigenous mental health outcomes.

The respect for the Indigenous mental health workforce is important for staff retention. There are inconsistencies across service locations and jurisdictions in the expected qualifications and scope of practice for Aboriginal and Torres Strait Islander mental health workers. This hinders opportunities for professional development, and in turn the respect for the professional status of these workers. There are flow-on effects to the wellbeing of the workers themselves, staff retention and remuneration.

Retaining the current workforce requires a focus on the wellbeing needs of the Indigenous mental health workforce by supporting Indigenous Australians in their current roles. Important elements include:

- valuing the role and providing career pathways
- embedding greater cultural respect in workplace practices
- providing peer support and mentoring.

Workforce research puts remuneration, career opportunities and respect high on the list of factors that attract people to a job in the first instance. These factors also help maintain staff commitment to their workplace and career. Personal and career development also improve workforce retention (Solowiej et al. 2010; Bailey et al. 2020).

A systematic review of the literature has confirmed the value of peer support and mentorship programs to the experience of Indigenous health workers (Lai et al. 2018). Of all the factors that influenced the retention of Indigenous staff in the health workforce, access to such programs was the greatest enabler of staff retention. Peer support predicted job satisfaction and reduced rates of stress and emotional burden for Indigenous health workers.

Indigenous leadership and control

A strong Indigenous mental health workforce and ACCHS promotes self-determination. This is important to mental health outcomes because Indigenous Australians are the experts on their own needs.

Self-determination in the development and delivery of suicide prevention efforts ensures responses are culturally safe and that they encapsulate an Indigenous SEWB conceptualisation of mental health, rather than clinical treatment alone (Dudgeon et al. 2020). Community control means Indigenous communities are more likely to have a long-term investment in prevention programs and efforts, resulting in positive future outcomes (Dudgeon et al. 2016).

Gayaa Dhuwi (Proud Spirit) Australia provides leadership for Indigenous SEWB, mental health and suicide prevention. It is governed and controlled by Indigenous experts and peak bodies working in these areas. It promotes access to culturally safe clinical treatments and Indigenous specialised areas of practice. Established in 2020, Gayaa Dhuwi brings together respected Indigenous health leaders, who are committed to expanding and strengthening the Indigenous mental health workforce.

Other national leadership bodies include the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Coalition of the Peaks. Both advocate for Indigenous self-determination and leadership, and work in partnership with other organisations and governments on health and wellbeing planning and policy.

There is a growing, body of research on the influence of ACCHS on primary health care outcomes (Campbell et al. 2017). Studies indicate a preference by Indigenous Australians for health service delivery from ACCHS over mainstream services. There is also evidence for greater adherence to treatment plans, above that of mainstream services (Mackey et al. 2014). Engagement from Indigenous clients has increased as ACCHS employ more Indigenous health staff who can deliver culturally safe health care programs, including mental health services (Panaretto et al. 2014).

Mental health services working together

Self-determination in mental health is supported by collaborations between ACCHS and mainstream mental health services. Such collaborations promote a sharing of knowledge, with this two-way learning increasing cultural awareness for staff in mainstream mental health services. These partnerships also enable the pooling of resources to increase clinical expertise and capability (Taylor and Thompson 2011).

Investment in relationship building is needed for meaningful partnerships; it facilitates trust and understanding between the ACCHS and mainstream mental health services. Discord in these partnerships may arise with mainstream services championing clinical skills, causing a sense of skill devaluation felt by Aboriginal health workers (Taylor et al. 2013). Mainstream services must be equipped with a level of cultural awareness that allows Indigenous conceptualisations of professionalism and approaches to client work to be valued as a strength (Taylor et al. 2013).

Other benefits to the partnership approach include:

- regular engagement by the mainstream service with the Indigenous community – this increases cultural understanding and builds community trust
- skill development and career progression pathways for Aboriginal health workers that are flexible and that support their goals – this will increase the capacity of the workforce as well as reinforce the value of the Aboriginal health workers
- partnerships that include consultation between stakeholders to embed culturally safe staff recruitment processes and ensure cultural awareness – this is a key training component for non-Indigenous staff (Opie et al. 2019).

Dudgeon and others (2016) described how partnerships between the Australian Government and PHNs should include service agreements that reflect the need for boards to include Aboriginal members as representatives of their communities. Community consultation should also be a priority when developing and implementing suicide prevention and intervention services. These are fundamental to the success of suicide prevention activities.

A ‘whole of systems’ approach that prioritises cultural competence is proposed. Mental health professional bodies are working towards increasing the numbers of Indigenous Australians in their professions, recognising the value of collaboration between Indigenous and non-Indigenous workforces. There are efforts being made to develop curriculums to ensure strong coverage of Indigenous Australian social and emotional wellbeing.

The Australian Indigenous Psychologists Association, for example, has made a commitment to ensuring the field of psychology in Australia represents Indigenous Australians and their culture through:

- providing cultural competence training to existing practitioners
- aiming to embed Indigenous Australian perspectives in university psychology curriculums.

Conclusions

Systematic studies and research regarding the benefits of ACCHS and Indigenous leadership for Indigenous mental health outcomes are limited; however, they are generally accepted to be important as they underpin cultural safety. More systematic research would help us understand who might be best served by whom and in what circumstances they should be served.

There is quite limited formal and informal evidence regarding the effectiveness of programs aiming to develop and strengthen the workforce. The involvement of Aboriginal and Torres Strait Islander people in evaluations of these Indigenous programs and policies will be important. We must hear about their impact from those who are expected to benefit.

Further, in gathering such evidence, it will be important to consider whether programs that have been successful in one context could be successfully implemented elsewhere.

Further restrictions to the evidence base for mental health workforce programs arise from the distributed nature of the programs, with:

- mental health programs often embedded within broader health policies and programs
- the difficulty of tracking the relationship between policies and programs at both the Commonwealth and state and territory levels.

Finally, Indigenous leadership can advocate for, and give advice about, a more systematic and national approach to building the knowledge base on this issue. This should be through peak professional bodies, ACCHS and other leadership organisations such as Gayaa Dhuwi.

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