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Improving Indigenous mental health outcomes with an Indigenous mental health workforce

Penney Upton, Linda Ford, Ruth Wallace, Sarah Jackson, Jenna Richard and Dominic Upton

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About the cover artwork:

Artist: Linda Huddleston

Title: The journey towards healing

At the centre of the artwork is the Clearinghouse. The black half-circles are the people who come to the Clearinghouse for information about mental health and suicide prevention.

The waves of red, yellow and white dots surrounding the inner circle represent strength and healing.

The footprints represent the journey towards healing.

The red and white circles around the edge represent different programs and policies aimed at helping people heal.

The hands represent success and wellbeing.

Summary

Improving mental health outcomes with an Indigenous mental health workforce

What we know

- There are high rates of psychological distress in the Aboriginal and Torres Strait Islander (Indigenous Australian) population. Suicide contributes to the gap between Indigenous Australian and non-Indigenous Australian mortality and life expectancy.
- An underrepresentation of Indigenous Australians in the mental health workforce is a key barrier to engagement with mental health services.
- Indigenous Australians have more cultural safety and trust in mental health services delivered by Indigenous mental health workers and professionals, who can deliver culturally relevant mental health services, with a holistic social and emotional wellbeing perspective.
- Aboriginal Community Controlled Health Services (ACCHS) employ Indigenous Australians as mental health workers. However, they must still rely on non-Indigenous staff because there are not enough clinically qualified Indigenous Australian staff. This could affect the cultural safety of services.
- Burnout and organisational factors reduce the retention of Indigenous mental health workers and professionals. There are also high non-completion rates for Indigenous students taking health courses in both tertiary and vocational education and training programs.
- Mental health services are often situated in mainstream services, so all mental health workers, especially non-Indigenous staff, must be culturally competent.
- Partnerships between ACCHS and mainstream mental health services improve cultural safety and cultural competence, increasing the options for care available to Indigenous Australians.

What works

- A strong Indigenous mental health workforce and ACCHS promote self-determination, which improves mental health outcomes. Indigenous Australians should be acknowledged as the experts on their own needs.
- Indigenous leadership can advocate for, and give advice about ways to improve and strengthen, the Indigenous mental health workforce. This should be through peak professional bodies, ACCHS and other leadership organisations such as Gayaa Dhuwi.
- Expanding and strengthening the Indigenous mental health workforce will increase the reach of mental health services to Indigenous Australians by providing culturally competent services.

- Initiatives to increase the cultural safety of mental health services include training the existing Indigenous workforce and expanding the available workforce through better training opportunities.
- The cultural safety of Indigenous mental health workers and Indigenous clients improves when policies are designed with Indigenous staff and local communities. It also improves when cultural competence is a key performance indicator for non-Indigenous workers.
- Embedding cultural competence and trauma-informed practice into post-secondary health practitioner training improves learner satisfaction and knowledge. It could also improve working practices and mental health outcomes.
- Considering the wellbeing of Indigenous Australian employees strengthens the Indigenous workforce and improves employee retention. This includes:
  - valuing health worker roles
  - recognising the strengths of their cultural values and ways of knowing
  - providing mentorship, networking, and professional development programs.

What doesn't work

- Partnerships between ACCHS and mainstream health services are strained when there is not enough time, effort and funding invested into building the relationship.
- Service delivery is unlikely to succeed without a strong foundation that has been built on trust and awareness of both parties' needs.
- Employing Indigenous mental health workers without training the non-Indigenous staff in how to respect and work with them does not work. The whole health system needs to be modified to integrate Indigenous services successfully, so the care of Indigenous Australians is shared across whole health care system.

What we don't know

- There are few studies which compare the mental health outcomes ACCHS with other services.
- Although the benefits of access to Indigenous health workers are known qualitatively, there are few studies that measure these benefits quantitatively.
- There are generic programs for health leadership. However, Indigenous specific programs may be more successful for Indigenous mental health workers. Indigenous leadership organisations should guide the development of any such programs.
- Due to a lack of systematic monitoring and evaluation, the impacts of workforce training initiatives, embedded curriculums, and workforce mentoring programs are unknown. Without this information, it is impossible to adapt programs and training to support mental health workers and, ultimately, the communities they serve.

1

Introduction

1 Introduction

Aboriginal and Torres Strait Islander people (hereafter 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). The literature suggests that many Indigenous Australians seek mental health care only when they become acutely unwell. This is past the point at which outpatient care or community-based programs might have reduced the significant impact of mental health issues on the individual and their family (Jorn et al. 2012).

Indigenous Australians have a holistic understanding of health encompassed by the notion of social and emotional wellbeing. Wellbeing is not an individualistic concept. For Indigenous Australians, wellbeing is tied to spiritual and cultural fulfilment, including a strong connection to Country (Department of Health 2013). Furthermore, it is intertwined with family and community (Dudgeon et al. 2014). The National Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing framework recognises this holistic view of health (Dudgeon et al. 2014). Good mental health is, therefore, situated within a holistic context. It is more complex than the absence of symptoms related to mental illness (Day & Francisco 2013).

The high rates of psychological distress in the Indigenous Australian population are well-reported (Markwick et al. 2014; Markwick et al. 2015). Suicide is also a notable issue, and contributes to the gap between Indigenous and non-Indigenous mortality and life expectancy (ABS 2019). This, combined with the low rate at which Indigenous Australians access mental health services, make addressing workforce shortfalls an imperative (Isaacs et al. 2010; Reifels et al. 2018).

An Indigenous mental health workforce can improve mental health outcomes for Indigenous Australians through access to appropriate, culturally safe and culturally competent services. It enables self-determination, which is an important aspect of good mental health and wellbeing (Dudgeon et al. 2014).

This review discusses:

- the importance of expanding and strengthening the Indigenous Australians' mental health workforce, and the Indigenous leadership of this workforce, for improving mental health outcomes for Indigenous Australians
- what the evidence says about how to increase the limited Indigenous mental health workforce (and leadership), including how educational, as well as workforce programs might help fill this gap
- how mainstream mental health services can work with Indigenous-led services to improve mental health and prevent suicide among the Indigenous Australian population, including examples of successful collaborations
- strategies to improve cultural safety to adequately meet the mental health needs of Indigenous Australians
- limitations of the evidence base, including the lack of available of data in this area, the lack of programs with a focus on the mental health workforce, and the distributed nature of the existing knowledge-base.

Appendix A contains a short description of relevant policies and legislation. Appendix B contains information about the programs and the methods used in their evaluations. See Appendix C for a summary of the methods used.

Indigenous Australians often report feeling unsure about new clinical environments, and they are uncomfortable about the way they are treated by non-Indigenous mental health staff (McGough et al. 2018). A large disconnect between the cultural values, worldview and language of the Indigenous person and the mental health service has been noted (McGough et al. 2018).

Systemic racism and discrimination experienced by Indigenous Australians can produce a lack of trust in mainstream health services (Canuto et al. 2018; Trueman 2013). Historical practices, such as the forced removal of children, shape modern day experiences (Canuto et al. 2018).This distrust is further compounded by limited cultural safety in many mainstream services.

Indigenous leadership and community control over the Indigenous mental health workforce and services can help build trust in Indigenous health services. According to the National Aboriginal Community Controlled Health Organisation (NACCHO), the benefits of their strong Indigenous Australian workforce include improved trust by Indigenous service-users, as demonstrated by a 20% higher client-retention rate compared to non-Indigenous Health Services (NACCHO 2018). Approximately 95% of health workers employed by ACCHS are Indigenous (Panaretto et al. 2014).

Cultural safety and cultural competence

Cultural safety refers to the provision of an environment that is physically, spiritually, socially and emotionally safe (Williams 1999). In a culturally safe environment, a person feels comfortable that they are accepted for who they are and what they need. Shared respect, meaning and knowledge are central to this concept. Culturally safe practices recognise and respect the cultural identities of other people, their values, beliefs. expectations and rights. In contrast, culturally unsafe practices disempower the individual, challenging their identity and wellbeing.

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). The Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health highlights the ways in which health services, including mental health providers, can support cultural safety. This can be achieved by strengthening the Indigenous Australian health workforce, as well as ensuring the cultural competencies of their existing workforce and systems.

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). To address this issue, the first of 6 goals developed as part of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (DoHA 2013) is to build the participation of an Indigenous Australian mental health workforce.

Cultural safety also plays a role in educating Indigenous health workers. Kurtz and others (2018) found that institutional support, strategic planning and a cultural safety curriculum policy were needed within post-secondary settings and community engagement. These measures improve student experiences and improved health for Indigenous people and communities.

Continued efforts to promote mental health environments that foster cultural safety is needed to reduce inequalities in metal health outcomes. The reason is that mainstream services can sometimes be preferred over Indigenous health services. Research has suggested that this choice is made typically because of convenience, including hours of operation and proximity to where someone lives (Canuto et al. 2018).

Cultural competency is the ability to understand, communicate and interact effectively across cultures. Culturally safe mental health services need practitioners who are culturally competent. These are practitioners whose intentions and actions build understanding between people, whatever their cultural background, and who are respectful and open to other perspectives.

A culturally competent workplace welcomes diversity, celebrates difference, and provides equality of opportunity. It also improves staff retention. Cultural respect from colleagues and supervisors within non-Indigenous mainstream services, along with mentorship and career progression opportunities, are therefore vital components to ensuring the wellbeing of Indigenous workers.

2

Background

2 Background

Studies into Indigenous Australian mental health show a disparity in mental health outcomes and access to services between Indigenous and non-Indigenous Australians.

Although ACCHS employ the majority of Indigenous mental health workers, they need more clinically qualified Indigenous staff (NACCHO 2019), as does the mainstream mental health workforce. The efficacy of mental health services for Indigenous Australians can be improved at a systemic level if mainstream services form partnerships with Indigenous communities and ACCHS.

Psychological distress and suicide

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 (Table 1).

Table 1. Rates of psychological distress, anxiety, depression and suicide in the Indigenous and general Australian population

	Indigenous Australians	Total Australian population
Psychological distress	31%	13%
Anxiety	17%	13%
Depresssion	13%	10%
Standardised suicide death rate (deaths per 100,000)	24.1	12.1

Source: ABS 2019; AIHW & NIAA 2020.

It is estimated that mental health problems contribute 12% of the gap in mortality and life expectancy between Indigenous and non-Indigenous Australians (Markwick et al. 2014). Suicide is in the top 5 causes of death for Indigenous Australians, with suicide rates almost double that of the general population (Table 1). In 2018 alone, 169 Indigenous Australians in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory died from suicide in 2018, which gives a standardised rate of 24.1 suicide deaths per 100,000 population (ABS 2019).

Of particular concern is the suicide rate for young Aboriginal males: it was the second most common cause of death in 2018 (ABS 2019). A total of 129 Indigenous Australian males died from suicide in 2018 (a standardised death rate of 38.1 deaths per 100,000). These young men had a median age of 31.8 years.

For Indigenous Australian females, suicide is the seventh most common cause of death (ABS 2019). In 2018, 40 Indigenous Australian females died from suicide (a standardised death rate of 10.3 per 100,000). The median age of female suicides is 26 years of age. The sex ratio of death from suicide is 76.3% to 23.7% is in line with the sex ratio of all deaths from suicide.

Access to services

Indigenous Australians access health services through mainstream primary health care services and Indigenous services provided by ACCHS. ACCHS are a national network that provides health care programs, including those underpinned by a Social and Emotional Wellbeing (SEWB) framework (Reifels et al. 2018). However, more than two-thirds of all ACCHS (68%) have identified SEWB as a gap in service delivery to the local community (AIHW 2019b).

Only around half of Indigenous Australians access ACCHS for any health care needs (AIHW 2019b), suggesting that the other half are likely to be largely reliant on mainstream services, if they access any mental health service at all.

The data suggest that access to mental health services could present challenges for Indigenous Australians. For example, in 2014–15, some 23% of Indigenous Australians experienced difficulties in accessing health services. This is comparable to the difficulties in access for people experiencing long-term health conditions (23%), but more than people with no long-term health condition (10%). This included mental health services, GPs and hospitals (ABS 2016a).

Mental health and wellbeing supports are often even more limited for people living in remote areas. According to psychiatry workforce data, the ratio of psychiatrists is 15.1 per 100,000 population in Australian metropolitan cities. In contrast, the ratio is only 5.0 psychiatrists per 100,000 population in remote areas and 1.4 per 100,000 in very remote areas. One of the reasons for this is a lack of psychiatrists willing to take up employment in remote and very remote regions (RANZCP 2019).

According to an Australian study (Sveticic et al. 2012), 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. In 2014–2015, Indigenous Australians accessed psychiatrists at a rate of 52 per 1,000, compared to a rate of 97 per 1,000 for non-Indigenous Australians, a disparity of 44.6% (AIHW 2019a).

Indigenous Australian mental health workforce

About 1.6% of all jobs across the entire health sector are held by Indigenous Australians (AHMAC 2015). Many of these are in ACCHS.

Just under half (46%) of all staff employed by ACCHS identify as Indigenous (AIHW 2019a). ACCHS comprised half of the 198 Indigenous Primary Health Services in 2017–18 but made up 91% of staff employed to deliver SEWB across 337 Indigenous Primary Health Services worksites (AIHW 2019a). Even so, more clinically qualified staff are needed in ACCHS (Panaretto et al. 2014). Just over half (53.6%) of the 3,768 clinical roles in ACCHS were filled by Indigenous Australians in 2017–18 (AIHW 2019a).

AIHW (2019a) reported that, in 2017–18:

- 68% of all Indigenous Primary Health Services reported SEWB as a gap in service delivery.
- 71% of these services expressed challenges in recruiting, as well as providing appropriate training and support to Indigenous Australian staff.
- Youth services have also been reported as a gap in more than half (54%) of Indigenous Primary Health Services. This is concerning given the high rates of suicide for young Indigenous males.

Issues of staff retention have also been described in the literature and are often related to burnout and organisational factors (Deroy & Schütze 2019).

Dropout rates for Indigenous students taking health courses in both tertiary and vocational education and training programs are also high. According to the Aboriginal and Torres Strait Islander Health Performance Framework Report (AHMAC 2017), 214 Indigenous students enrolled to study medicine in 2015. Although medical degree completion rates for the same year were not published in the framework, Medical Deans (2021) reported that 35 Indigenous doctors graduated in 2016. This was a 130% increase on the previous 5 years. Despite this growth, Australian Indigenous medical graduates made up only 1.4% of all medical students graduating in Australia in 2017 (Medical Deans 2021).

Reasons for poor completion and retention rates include rates of bullying and poor cultural safety, racism and the need to accomodate cultural obligations.

The prevalence of racism is a key contributor to lower retention of Indigenous Australian health professionals, as well as student attrition in health and medical university courses (Taylor at al. 2019). Indigenous health workers have reported systematic and individual racism in education and health environments, such as accusations of benefiting from their heritage financially or through privileged career progression opportunities. Beyond Blue's national health survey found the Indigenous medical students and doctors experienced bullying 5 times more frequently, and racism 10 times more often, than their non-Indigenous peers (Australian Medical Students Association 2019).

Cultural obligations have a material effect on Indigenous Australians' education experience—they are more likely to need to respond to crises within their family or community, such as illness or sorry business, during their studies. Even when physical engagement at university is not disrupted, the psychological distress experienced due to family and community problems is highly impactful (Taylor et al. 2019).

Indigenous health professionals and students are better supported when workplaces and academic institutions:

- recognise the importance of peer mentorship opportunities and programs
- support pathways for Indigenous students who are away from their community, for example, by providing liaison officers.

The Australian Indigenous Doctors' Association is a professional body that supports medical students and doctors in this way. They provide opportunities for peer support and networking at organised events (Australian Medical Students Association 2019).

Cultural safety in mainstream services

Limited consideration of Indigenous Australian's conceptualisations of health and mental health, including the centrality of culture, is a recognised barrier to health system access (AHMAC 2016).

Close to 90% of health-related mainstream workplaces provide cultural safety training to staff members. However, only 60% of workplaces define this as a staff competency that is monitored during staff performance appraisals (AHMAC 2017).

In 2017–18, just over three-quarters (77%) of cultural safety policies in primary health care services (including mental health services) were reported to have been developed in consultation with Indigenous Australian staff members and communities. This was an improvement from 2012–13, when consultation was included in the development of only 6.5% of policies (AIHW 2019a).

Most of these services (83.9%) reported having systems in place to seek cultural advice when necessary. Less than half of these services, however, reported having interpreter services available for clients (40%) or incorporating cultural services such as traditional healing and bush medicine into their service-delivery model (32%).

3

Key issues

3 Key issues

This section seeks to answer the following 3 questions that are key issues for supporting Indigenous Australians' mental health outcomes through an Australian Indigenous mental health workforce:

- How will an expanded and strengthened Australian Indigenous mental health workforce improve mental health outcomes for Indigenous Australians?
- Why is Indigenous leadership and community control of this workforce important for mental health outcomes for Indigenous Australians?
- How can Indigenous-specific and mainstream mental health services best work together to improve mental health and reduce suicide among Indigenous Australians?

An expanded and strengthened workforce

Expanding and strengthening the Australian Indigenous mental health workforce will improve the cultural safety experienced by service-users. For the effective provision of mental health care services, a person's cultural and spiritual beliefs need to be considered.

The Indigenous Australian conceptualisation of mental health and wellbeing is holistic: it includes spiritual fulfilment and a strong connection to culture and Country. Wellbeing is not individualistic, but is intertwined with family and community (AIHW 2018). Therefore, the mental health needs of Indigenous Australians must be addressed from a wider SEWB perspective (Day & Francisco 2013).

Cultural safety improves when these needs are understood (AHMAC 2016) and truly underpin service delivery. Cultural safety is the outcome experienced by health care recipients and Indigenous mental health workers and professionals, who share an intrinsic understanding of Indigenous cultural beliefs and ways of knowing (Aboriginal Resource and Development Services Corporation 2015).

Building trust

A lack of trust in non-Indigenous mainstream health services is deep-seated for many Indigenous Australians and communities. This is partly a result of past political actions, such as the forced removal of children from Indigenous families (Canuto et al. 2018; HREOC 1997). It is also a result of ongoing systemic racism and discrimination, which materially contribute to Indigenous Australians hesitating before engaging with mainstream health services (Canuto et al. 2018; Trueman 2013).

Ward (2017) found that Indigenous Australians were less likely than other cultural groups to participate in a health screening due to a distrust of the government and its services. Distrust is further compounded by a lack of cultural safety and competence provided by many mainstream mental health services.

Racism and discrimination detract from efforts to build trust. The result is a failure to provide equitable access to mental health care (Durey et al. 2012) due to ongoing systems and practices that do not respond in a culturally competent manner to the mental health needs of Indigenous Australians. Examples include:

- the employment of non-Indigenous health professionals who have not undertaken cross-cultural training or who do not attempt to understand local cultural values in relation to social and emotional wellbeing (Durey et al. 2012)

- a hospital ward that imposed a maximum 2-visitor rule, which fails to consider the central role of family for Indigenous health and wellbeing (Durey et al. 2012).

Indigenous Australians have reported feeling unsure about new clinical environments and uncomfortable about the way they are treated by non-Indigenous mental health staff (McGough et al. 2018).

Language barriers make it more difficult to build trust as Indigenous Australians often have a poorer experience when accessing mainstream mental health services (Durey et al. 2012). A Northern Territory Study found professional interpreters were not frequently utilised in a hospital setting due to resource and logistical constraints (Ralph et al. 2017). Some staff reported that the time needed to organise and access an interpreter did not support the fast-paced ward environment, or that they were unsure of when an interpreter should be utilised.

An expanded and strengthened Indigenous workforce will improve cultural safety and thereby the trust of Indigenous Australians in services. This will enable greater participation of Indigenous Australians in mental health programs and may contribute towards closing the gap in mental health outcomes.

A qualified and respected workforce

A large proportion of the Indigenous Australian mental health workforce is made up of Aboriginal and/or Torres Strait Islander Health Workers (ATSIHW). ATSIHW must have a minimum qualification of a Certificate IV in Aboriginal and/or Torres Strait Islander Health Care (Practice) to be registered as a practitioner with the Australian Health Practitioner Regulation Agency.

The job roles of ATSIHW have several titles. The term 'Aboriginal and Torres Strait Islander Mental Health Worker' is often used to refer to Indigenous Australians whose roles focus on mental health or emotional and social wellbeing, but there is no nationally agreed definition. Different states and territories require a different level of qualification and experience.

The National Aboriginal and/or Torres Strait Islander Health Worker Association (NATSIHWA 2019) provides a framework for determining the scope of practice for ATSIHW more broadly. That scope includes the level of worker education, competencies and professional registration, but ultimately, it is defined locally depending on job, context, service location and jurisdiction.

This flexibility has some strengths, but upskilling and more opportunities for professional qualifications and on-the-job training are more effective. These factors enhance competencies and the service provided to communities. They also increase the respect for the professional status of health workers. This is important for the wellbeing of the workers themselves. It reinforces the value of their role, which also increases staff retention. This is partly because gaining a high-level, nationally recognised qualification will result in better remuneration.

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. In many ways, this could simply be seen as putting people and their needs first (Dessler 1999). There is also evidence that financial incentives are less important than opportunites for personal and career development are for improving workforce retention (Solowiej et al. 2010). This view is reinforced by recent evidence provided by the Lowitja Institute, which underlined the importance of strengthening and supporting Indigenous Australian leadership and reinforcing and embedding career pathways in health care settings to enhance employment and retention for the Indigenous workforce (Bailey et al. 2020).

An example of how this might evolve is provided by the Djirrwang program (see page 25 for more detail). The program was first developed initially as a strategy to advance the Indigenous mental health workforce in New South Wales, but it now focuses on the recruitment, retention and status of Indigenous mental health workers. The program is clearly successful: from its early beginnings as a local NSW pilot, it has now expanded to cover 5 states and territories.

Professional represention

Indigenous Australians across the mental health workforce are not well represented in professional bodies. This is explained in part by the high dropout rates for Indigenous students taking health courses in both tertiary and vocational education and training programs. Increased training and educational opportunities could help strengthen and expand this representation.

For example, Indigenous membership is:

- 0.1% for fully qualified psychiatrists and 0.7% for trainees, according to the Royal Australian and New Zealand College of Psychiatry (RANZCP) 2016–18 Reconciliation Plan (RANZCP 2016)
- 0.4% for the Australian Indigenous Psychologists Association (AIPA).

Further:

- 706 out of 21,128 people who reported their occupation as a social worker identified as Indigenous. It is not known how many were registered with the Australian Health Practioners Regulation Agency or the Australian Association of Social Workers or how many registered their Indigenous status with those organisations (ABS 2016b).
- 606 out of 17,756 people who reported their occupation as a counsellor identified as Indigenous. Membership data for the Psychotherapy and Counselling Federation of Australia (PACFA) were unavailable (ABS 2016b).

RANZCP, AIPA, AASW and PACFA have all declared an intent to increase recruitment and retention of Indigenous Australians to their professions. Their aim is to bring participation to a more equitable 2.5%. This participation rate would directly improve mental health outcomes for Indigenous Australians by increasing:

- the opportunity for Indigenous Australians to access care from Indigenous Australian clinicians
- the wellbeing of the workforce through enhanced employment opportunity
- Indigenous empowerment through mental health workforce leadership and professionalisation.

Emergency responses

The importance of cultural safety and the urgent need for an Indigenous Australian mental health workforce was further highlighted during the COVID-19 pandemic of 2020.

In May 2020, the federal government allocated an extra $48.1 million to mental health services under the National Mental Health and Wellbeing Pandemic Response Plan (National Mental Health Commission 2020). This money was provided in recognition of the pressures that such services were facing.

Indigenous organisations, including Indigenous Allied Health Australia (IAHA) and AIPA, welcomed the funding. They also reiterated the importance of using an Indigenous mental health workforce to deliver culturally competent services for frontline responses, domestic and family violence supports,

and for telehealth counselling services (AIPA 2020; IAHA 2020). The CEOs of both Gayaa Dhuwi and IAHA highlighted the existing strong, skilled and qualified mental health and SEWB workforce. These experienced mental health specialists have an important role in supporting Indigenous Australians (IAHA 2020).

Suicide prevention

Similar issues underpin the provision of suicide prevention support and services for Indigenous Australians.

Suicide prevention efforts should embody a SEWB conceptualisation of mental health, which can be best provided by ACCHS (Central Australian Aboriginal Congress 2019). Services must be culturally safe and led by Indigenous mental health professionals, who are best placed to provide trauma-informed and culturally safe services.

Strengthening and expanding the Indigenous Australian mental health workforce in this way will provide more and better-paid jobs for Indigenous Australians.

This approach provides a vital contribution to 'suicide proofing' the Indigenous Australian population (Dudgeon et al. 2016) through a mix of:

- empowerment
- increased self-determination
- action on social determinants such as unemployment and disadvantage.

These factors will be addressed in other Clearinghouse publications.

Dudgeon and others (2016) found that celebrating cultural identity was important to Indigenous Australians. It was an important factor in suicide prevention and intervention responses. Additionally, building suicide prevention and intervention responses with an understanding of Indigenous Australian healing that included a holistic SEWB perspective demonstrated most success (Dudgeon et al. 2016).

When Indigenous Australians provide mental health services, Indigenous conceptualisations of healing and SEWB can be incorporated into the service at a fundamental level. This contributes to the cultural appropriateness and competence of suicide prevention and intervention services.

Indigenous leadership and community 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 and shared ways of knowing, which promotes promote cultural safety and competence (Campaspe Primary Care Partnership 2017).

The history of inequality and discrimination means that leadership and control must be returned to Indigenous communities. In this way, services that include Indigenous cultural values and ways of knowing can be developed and delivered. This will be achieved through cultural knowledge, which is possessed only by Indigenous people and communities themselves (Campaspe Primary Care Partnership 2017). Because Indigenous communities across Australia are culturally diverse, local ACCHS are best placed to deliver mental health services that use an Indigenous conceptualisation of mental health within the context of unique communities and cultural values (Weightman 2013).

National leadership bodies

Gayaa Dhuwi (Proud Spirit) Australia

Broad leadership for Indigenous SEWB, mental health and suicide prevention is provided by Gayaa Dhuwi (Proud Spirit) Australia. This national leadership body was established in March 2020, taking on the role originally filled by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) from 2014 to 2020.

In 2015, NATSILMH launched the Gayaa Dhuwi (Proud Spirit) Declaration. It aimed to achieve the 'highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander Peoples' (NATSILMH 2015).

As a leadership group, Gayaa Dhuwi is governed and controlled by Indigenous experts and peak bodies working in these areas. It promotes collective excellence in mental health care. This includes advocacy for improved Indigenous mental health workforce as described in the:

- Gayaa Dhuwi Declaration
- Fifth National Mental Health and Suicide Prevention Plan (COAG 2017)
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 (PM&C 2017).

Gayaa Dhuwi also supports systems thinking by promoting access to both culturally safe clinical treatment and Indigenous specialised areas of practice (for example, cultural healers and SEWB and mental health teams).

At the time of writing, Gayaa Dhuwi is still a relatively new organisation, so its impact has not yet been established. The potential influence of the board on matters such as expanding and strengthening the Indigenous mental health workforce should not be underestimated: it brings together highly respected Indigenous leaders from a broad range of relevant health bodies including ACCHS, AIPA, IAHA, Australian Indigenous Doctors Association, Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, and the National Indigenous Critical Response Service.

National Aboriginal Community Controlled Health Organisation (NACCHO)

As the peak national body for ACCHS, NACCHO currently represents 143 members from across Australia. Each service within the NACCHO membership comprises a network, but each is autonomous of the others and has its own locally elected board of management.

NACCHO embodies self-determination in Indigenous Australian health and wellbeing. It works to widen health and wellbeing services through ACCHS. It establishes cooperative partnerships with agencies that respect Indigenous community control and holistic concepts of health and wellbeing (NACCHO 2018). NACCHO also provides advocacy for Indigenous self-determination and leadership, and it works with organisations and governments on health and wellbeing planning and policy in both Indigenous and non-Indigenous health spaces.

Coalition of the Peaks

More than 50 Indigenous Australian community-controlled peak and member organisations make up the Coalition of Peaks. This organisation was formed as an act of self-determination as part of supporting the Australian Government in its renewed efforts towards Closing the Gap. In 2019,

a formal agreement was signed between the Council of Australian Governments and the Coalition of Peaks to ensure that Indigenous Australian organisations are involved in decision-making regarding Closing the Gap, including design, implementation, and monitoring of activities and policy. This formal arrangement is an Australian first. It will stand in place for 10 years and will see Indigenous Australian-led reviews of Closing the Gap every 3 years (Coalition of Peaks 2020).

History of ACCHS and how many exist

Only a small, but growing, body of research has examined the influence of ACCHS on primary health care outcomes, including mental health (Campbell et al. 2017). However, available studies across a range of health-contexts suggest Indigenous Australians might prefer to access ACCHS above mainstream health services.

Proposed reasons for this preference include having a greater sense of trust in dealing with ACCH staff, ACCHS services being more geographically accessible, and a better range of services (Mackey et al. 2014).

Some studies found that engagement with an ACCHS increased adherence to treatment plans above that of mainstream services (Mackey et al. 2014). Furthermore, some ACCHS have demonstrated a client-retention rate that is 20% higher than non-Indigenous Health Services (NACCHO 2018). 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). Study findings can also be explained in part by ACCHS cultural practices, which attend to an individual's SEWB holistically, rather than relying on clinical treatment alone (Alford 2014).

More Australian research is needed to measure the benefit of ACCHS for improved mental health outcomes through an expanded and strengthened Indigenous workforce. Overseas studies can also provide further insight. For example, research from Canada demonstrates the successes of community control for increasing Aboriginal engagement with mental health services (Dudgeon et al. 2014).

Suicide prevention

Indigenous leadership and community partnership is a best-practice approach to implementing suicide prevention and intervention programs (Dudgeon et al. 2016). 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).

Indigenous leadership will allow Indigenous Australians to access 'the best of both worlds in mental health' by including cultural healers and traditional approaches to recovery through language, culture and connection to Country. It also allows for the lived experiences of Indigenous people to be considered.

Importantly, 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). Overseas suicide prevention research supports self-determination as a protective factor. For instance, self-government, on-reserve health services and access to cultural facilities have been identified as key factors to reducing rates of suicide among Indigenous Canadians (Dudgeon et al. 2014).

In synthesising success factors related to suicide prevention, Dudgeon and others (2016) found leadership and self-determination was especially important for young people. Self-determination fosters empowerment and ownership of the suicide prevention and intervention responses. Importantly, it means local cultural knowledge can be used to develop responses that have been effectively tailored to meet the diverse needs of Indigenous communities and cultural groups (Dudgeon et al. 2016).

For example, a key finding of a recent study was the interest that young Indigenous Australians showed for e-mental health resources such as SMS (Povey et al. 2020). Many young people preferred to seek anonymous support or referred to an internet search engine for advice. They also felt a lack of trust in mental health services, shame in talking to someone they didn't know, and lack of confidence that the service. In the study, young Indigenous people enjoyed using mental health tools that were fun and that used story telling. Importantly, there were preferences between ages, males and females and language groups.

The study showed that tailoring mental health services and tools to these preferences is important: it relies on both Indigenous leadership and Indigenous workforce capacity. As for other services, innovative approaches such as e-health and telehealth counselling services need a skilled Indigenous mental health and SEWB workforce to succeed (AIPA 2020; IAHA 2020).

Mental health services working together

There is evidence that Indigenous self-determination in mental health is supported by collaborations between ACCHS and mainstream mental health services. Not everyone has access to ACCHS or chooses to access ACCHS.

Indigenous Australian clients do not always want to see an Indigenous mental health worker. Instead, people should be given the opportunity to express a preference (Cosgrave et al. 2017). A systems approach through partnerships will improve the cultural competency and reach of mainstream mental health services (Campaspe Primary Care Partnership 2017).

Working with an ACCHS and Indigenous colleagues has positive flow-on effects for staff in mainstream mental health services, including improved cultural awareness, which occurs through a two-way learning process. For example, McGough and others (2018) presented a grounded theory study in which non-Indigenous mental health practitioners reported that they improved their understanding of Aboriginal culture and could provide better support to their Indigenous clients when they sought support from their Indigenous colleagues. This support-seeking must be conducted with respect to professional boundaries. For example, research has described how overwhelming it can be for Indigenous mental health workers to feel that they are the sole 'cultural consultant' and that they must be 'everything to everybody' (Cosgrave et al. 2017).

Cultural competence: A systems approach

ACCHS and non-Indigenous organisations can do more than share knowledge. They can also pool resources to deliver services with increased cultural competence, clinical expertise and capability (Taylor & Thompson 2011). For instance, although ACCHS has strong mental health worker representation, they need more clinically qualified Indigenous staff (NACCHO 2018).

Professional bodies such as AIPA and RANZCP acknowledge this gap and are working towards increasing the number of Indigenous Australians in their respective professions. They recognise the value of collaboration between Indigenous and non-Indigenous workforces and the importance of increasing the cultural competence of the mental health workforce.

The AIPA, for example, has committed to working towards improving the mental health system overall and ensuring the field of psychology in Australia represents Indigenous Australians and their culture. This includes:

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

This 'whole of systems' approach prioritises cultural competence. It places knowledge and understanding of cultural factors at the front and centre of professional training, rather than treating it as an add-on or optional specialisation.

It is not just about changing the quality and content of the curriculum. It also requires mentoring of Indigenous students and promoting community-relevant Indigenous research (Mahmut 2018). Without addressing these broader environmental factors, global evidence suggests the quality of the curriculum is insufficient for engendering change (Mahmut 2018).

Attempts to develop curriculums with strong coverage of Indigenous Australian and emotional wellbeing are widely reported. For examples, studies reveal:

- wealth of good advice on how to achieve this (Dudgeon & Walker 2015)
- broad range of resources to support change (Cranney et al. 2019)
- reports of a positive impact on student learning (Ranzljn et al. 2008).

The impact of these efforts to decolonise psychology has yet to be established. This could change as the resources and framework for change are provided by the Australian Indigenous Psychology Education Project. Funded by the Office for Learning and Teaching in the Australian Department of Education and Training, the final project report provided detailed guidance on how masters level psychology courses could arrange their curriculum to produce a graduate workforce with appropriate capabilities (Cranney et al. 2019). The project report found that work-integrated learning was recognised as an important learning approach that would allow psychology students the opportunity to form meaningful partnerships with Indigenous Australian organisations for two-way learning.

Building relationships and networks

Relationship building and networking are key factors for establishing meaningful partnerships (SNAICC 2012). This applies at the undergraduate program level as well as in a collaboration between ACCHS and mainstream mental health services.

Recognising the importance of this process and investing in it is key because it facilitates trust and understanding between the ACCHS and mainstream mental health services. For example, Taylor and others (2013) examined a partnership between one ACCHS and a mainstream service in an alcohol and other drug service setting. They found that both organisations conveyed a lack of knowledge about the other. This resulted in some distrust, which was exacerbated by a funding reallocation to the mainstream service without consultation with both stakeholders. This incident demonstrates how partnerships can be strained when decision-making and funding is not shared equally.

This example shows how the development stage of partnership building is the best time to clarify roles and expectations of each organisation, discuss the sharing of funding resources, and agree on mutual objectives. Additionally, it exemplifies the need for a commitment to shared decision-making at all stages in partnerships, from identifying the problem, policy development and impementation activities, through to outcome evaluations (Hunt 2013).

For example, co-designing measures of effective service delivery embodies shared decisionmaking at an early stage. Such measures should capture the cultural perspectives of the ACCHS, the mainstream service, and funding bodies (Taylor et al. 2013). Formalisation of arrangements means the partnership direction and commitment from each partner is clear (SNAICC 2012). Resources to support the development of partnerships more generally could also be useful in this regard. For example, the Victorian Health Promotion Foundation have produced a comprehensive tool for supporting partnership development across sectors (VicHealth 2016).

It takes more than building rapport. What is also needed is an awareness and acceptance of how diverse cultural values could influence work practices. For instance, a point of discord in partnerships has been a sense of skill devaluation felt by Aboriginal health workers (Taylor et al. 2013). ACCHS place value on knowledge of community and understanding the client within their sociocultural context. They determine worker competency in these terms, but mainstream services often champion clinical skills (Taylor et al. 2013).

Ensuring mainstream services are equipped with a level of cultural awareness allows Indigenous conceptualisations of professionalism and approaches to client work to be valued as a strength (Taylor et al. 2013). Although two-way learning occurs in shared service-delivery models, mainstream health services must commit to actively developing their cultural competency to support a cohesive partnership (SNAICC 2012).

Partnerships that are based on these values will embody the core principles of community engagement, being integrity, inclusion, deliberation and influence (Hunt 2013).

Other ways in which Indigenous-specific and mainstream mental health services can best work together, 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 ensuring cultural awareness—this is a key training component for non-Indigenous staff (Opie et al. 2019).

The Njernda Partnership Model

The Njernda Partnership Model is an example of a partnership program that used these strategies to deliver positive outcomes for mental health service delivery in the Murray and Campaspe regions of Victoria.

The partnership was formed in 2010 on the back of the release of the Closing the Gap Strategy and its initiatives. Njernda Aboriginal Corporation and Campaspe Primary Care Partnership understood that a partnership would best support the implemetation of the initiatives at a local level. During the first meeting, roles and responsibilities of each stakeholder were discussed and it was agreed that representatives attending meetings should have the authority to make decisions on behalf of their organisation (Njernda Aboriginal Corporation 2017).

The partner organisations include a range of government and community health services. Early in the relationship, they co-designed an Aboriginal health profile. This helped identify policies and strategies with a common focus and shared direction. Cultural awareness continues to be raised through mainstream staff training. There is also a cooperative celebration on dates with cultural importance. This helps foster a connection between the mainstream service and the local community (Njernda Aboriginal Corporation 2017).

Suicide prevention

Partnership and support from mainstream mental health services is important to the success of suicide prevention and intervention programs (Campaspe Primary Care Partnership 2017; Isaacs & Sutton 2016).

As identified in Povey and others (2020) and Dudgeon and others (2016), access to e-health and telehealth services has been identified as a positive suicide prevention response by Indigenous Australians. Young people especially prefer the anonymity of these technologies (Povey et al. 2020). There is scope for ACCHS and mainstream services to work together by sharing cultural knowledge and resources. This would provide increased access to mental health services that fits the needs of Indigenous Australians.

Dudgeon and others (2016) described how partnerships between the Australian Government and Primary Health Networks should include service agreements that reflect the need for boards to include Aboriginal members as representatives of their communities. It was also noted that community consultation should always be a priority when developing and implementing suicide prevention and intervention services. The involvement and input from Indigenous communities at all stages is integral to effective, enduring partnerships.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) emphasises that partnering with community members is fundamental to the success of suicide prevention activities. This is especially the case during assessment and planning stages, in which the needs of individual communities must be identified, as well as during evaluative activities in which community feedback is invaluable. In developing future activities, these feedback and views of the local community should be a priority consideration (Dudgeon et al. 2016).

ATSISPEP recommended key performance indicators (KPIs) be included in service agreements between Australian Government and Primary Health Networks (PHNs); the KPIs should incorporate these necessary partnership characteristics. Inclusion of KPIs would be a step towards ensuring partnerships between PHNs and Indigenous communities are appropriate (Dudgeon et al. 2016).

To further strengthen accountability to these partnerships and promotion of community leadership, PHN advisory and government forums should ensure they include appropriate representation by Indigenous community members and leaders (Dudgeon et al. 2016).

According to the Black Dog Institute (2018), capacity building and education for frontline workers such as general practioners (GPs) is one of the most promising interventions for reducing suicide. Cultural awareness training is often mandatory for GPs and medical students, but curriculums are often inconsistent and training is sometimes *ad hoc* (Watt et al. 2016). Although GPs and registrars attend workshops, much training and oversight of cultural competence falls to clinical supervisors. However, supervisors feel underskilled and that they lack the understanding of Indigenous Australian cultures needed to effectively assess and monitor the cultural competence of their supervisees (Watt et al. 2016).

Aside from formal training, another strategy to support GPs in providing culturally competent care is workplace mentorship provided by Indigenous Australian staff. Indigenous Australian mentors have identified areas in which GPs need to further develop their cultural competencies (Abbott et al. 2014; Watt et al. 2016), including:

- deepening their understanding of mental health in the context of Australia's history of colonisation and intergenerational trauma
- improving their communication styles
- building relationships with Indigenous health care staff and clients
- using the appropriate terminology when referring to Indigenous Australians
- working with families as well as the individual in treatment
- providing a comfortable environment through signage that acknowledges Country and culturally relevant posters and reading materials.

Mental health training also supports primary care workers in the identification and referral of patients with mental health symptoms to appropriate services. It is one of 9 evidence-based strategies being provided by the LifeSpan project, which is being piloted in New South Wales.

According to modelling data, LifeSpan aims to prevent 21% of suicide deaths and 30% of suicide attempts. Although not Indigenous specific, the Institute is working closely with the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention to determine the most culturally appropriate ways of implementing the program for Indigenous Australians (Dudgeon et al. 2018).

4

Policy context

4 Policy context

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. See Appendix A.

National strategic frameworks

The Australian Government has implemented 5 relevant, overarching strategic frameworks:

- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023
- The Aboriginal and Torres Strait Islander Health Curriculum Framework
- Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

This framework was designed to complement the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). The aim is to guide the development of policies and practices related to Indigenous mental health in Australia. Additionally, the framework aims to contribute to achieving the Council of Australian Governments' Closing the Gap target for Indigenous and non-Indigenous Australians' life expectancy equality (as a measure of health equality) by 2031.

Action Area 1 in the framework identifies the need for an effective and empowered mental health workforce. In 2018, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) called for targets and a funded implementation plan to be drawn up in partnership with Indigenous mental health leaders. This implementation component is to be developed during 2020–2021 by Gayaa Dhuwi, the current leadership group for Indigenous mental health and SEWB in Australia.

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The overarching objective of the strategy is 'to reduce the cause, prevalence and impact of suicide on individuals, their families and communities' (Department of Health 2013). The framework is informed by extensive Indigenous community consultation across Australia.

The framework has 6 goals, one of which is to:

> *Build the participation of Indigenous Australianss in the workforce in fields related to suicide prevention, early intervention and SEWB through the provision of training, skills and professional qualifications at all levels.*

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023

This framework was prepared to support the development of policy and strategy for Australia's Indigeous workforce across all health domains. Centrality is given to culture, health systems effectiveness, partnership and collaboration, leadership and accountability, as well as evidence and data (ATSIHWWG 2017) .

The framework was developed in the overall policy context of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. It provides cross portfolio linkage between several Australian Government Departments including Prime Minister and Cabinet, Education and Training, Human Services, and Health as well as corresponding Ministries within states and territories.

The framework is also consistent with:

- the Cultural Respect Framework 2016–2026, which commits the Australian Government and all states and territories to embedding cultural respect principles into Workforce development and training
- the Aboriginal and Torres Strait Islander Health Curriculum Framework, which supports higher education providers to develop cultural capabilities in undergraduate training across health professions. The aim is to prepare graduates to provide culturally safe services to Indigenous Australians.

Aboriginal and Torres Strait Islander Health Curriculum Framework

Good health care outcomes for Indigenous people require health professionals to be both clinically and culturally capable.

The framework aims to prepare health graduates to provide culturally safe health care to Indigenous peoples through the development of their cultural capabilities as undergraduate students.

The framework includes resources, suggestions and guidance to higher education health programs to support the integration of Indigenous curriculums into their courses. The framework also assists accreditation bodies in identifying an expected standard when assessing Indigenous curriculums with health courses and training programs.

Cultural Repect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health

Developed for the Australian Health Minister's Advisory Council (AHMAC) by the National Aboriginal and Torres Strait Islander Health Standing Committee, this framework envisions an Australian health system that is accessible, reponsive and safe for all Indigenous Australians. The framework is guided by the 5 key principles of leadership and responsibility, health equality and a human rights approach, Indigenous community and consumer engagement, partnerships and monitoring and accountability. The framework also outlines several domains and focus areas, including workforce development and training. This domain focuses on the Indigenous health workforce and leadership and developing a culturally responsive health workforce.

PHN Primary Mental Health Care Flexible Funding

Support for delivery of services against these frameworks is provided in part by the Australian Government's flexible fund for PHNs. This fund supports commissioning of mental health and suicide prevention services in 6 key service delivery areas, including services for Indigenous Australians. In 2019 the government committed more than $1.45 billion to this fund for 2019–2020 to 2021–22 (3 years). This included $77 million for suicide prevention (including Indigenous suicide) and $89 million for Indigenous mental health services.

Funding is quarantined for provision of Indigenous mental health services under the Indigenous Australians' Health Programme. The aim is to ensure PHNs can achieve a key objective:

> *enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level facilitating a joined-up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.*

Although the funding is not workforce specific, there is an expectation that the funding will enable PHNs to engage in workforce development and address service and workforce gaps (PHN Advisory Panel on Mental Health 2018).

Specific implementation guidance was provided for PHNs in relation to the planning and commissioning of mental health services for Indigenous Australians (Department of Health 2019). According to this guidance, individual PHNs should determine the most suitable workforce on the basis of the availability of trained and qualified people who have clinical and cultural competency. This includes:

- planning for a workforce trained in building culture into therapy by integrating the worldviews of clients and their family into the service provided
- providing access to training in trauma-informed care
- the delivery of services which will holistically meet the needs of Indigenous Australians.

They are also strongly advised to co-design services in partnership with Indigenous Australian leadership and Aboriginal Community Controlled Health Organisations (ACCHOs) and to ensure a joined-up service provision with clear referral pathways. This integration of services should include drug and alcohol services, suicide prevention, SEWB services, and mainstream mental health services.

State and territory workforce strategies

Workforce strategies at the state and territory level include the principles of these national frameworks, although not all are specific to mental health:

- NSW Health Good Health. Great Jobs Aboriginal Workforce Strategic Framework 2016–2020
- Victoria's Balit Murrup
- Queensland Health Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026
- WA Health Aboriginal Workforce Strategy 2014–2024
- SA Health Aboriginal Workforce Framework 2017–2022
- Tasmanian State Service Aboriginal Employment Strategy to 2022 and the related Aboriginal Employment Action Plan 2019–2022

- ACT Government Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018
- The NNorthern Territory (NT) Aboriginal Cultural Security Framework 2016–2026.

NSW Health Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016–2020

This framework aims to support health services and organisations across New South Wales to expand and strengthen their Aboriginal health workforce.

The framework is built on 6 points of focus:

1. lead and plan Aboriginal workforce development
2. build cultural understanding and respect
3. attract, recruit and retain Aboriginal staff
4. develop the capabilities of Aboriginal staff
5. work with others to achieve workforce priorities
6. track achievements and improve results.

Victoria's Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027

The objective of Balit Murrup is to reduce the high rates of suicide, psychological distress and poor mental health outcomes for Indigenous Victorians in relation to their non-Indigenous counterparts.

To do this, Balit Murrup seeks to support Aboriginal people, their families and communities in achieving excellent social and emotional wellbeing and mental health. A key focus of Balit Murrup in achieving this objective is reforms of employment in the Aboriginal health sector, including emphasis on Aboriginal self-determination.

Queensland Health Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026

The Queensland Health Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026 aims to promote increased access to culturally safe and competent health services to Indigenous Australians through a strong Aboriginal workforce.

The framework was developed to align with Queensland Government's Moving Ahead—A strategic approach to increasing the participation of Indigenous Australians in Queensland's economy 2016–2022.

There are 6 priority areas:

1. increasing the number and proportion of Indigenous people employed by Queensland Health
2. expanding Indigenous Australian employment across all domains of health and professions
3. building partnerships with other health and education providers
4. providing leadership and planning for Indigenous workforce development
5. employing more Indigenous health graduates
6. building an Indigenous Australian workforce that supports efforts to close the gap between Indigenous and non-Indigenous Australians through provision of culturally safe and competent health services.

WA Health Aboriginal Workforce Strategy 2014–2024

This strategy supports the Aboriginal and Torres Strait Islander Employment Framework Business Plan 2008–2013. It focuses on attraction and retention, workforce skill development, workforce design and workforce planning and evaluation. By implementing initiatives across these focus areas, the strategy aims to support long-term growth of the Aboriginal health workforce, particularly in the area of clinical and non-clinical leadership.

SA Health Aboriginal Workforce Framework 2017–2022

The SA Health Aboriginal Workforce Framework 2017–2022 aims to expand the Aboriginal health workforce, with a focus on leadership in both clinical and non-clinical roles. The framework aims to diversify and improve the services provided by South Australian health services to Indigenous Australians, including strengthening the cultural safety of health services.

Tasmanian State Service Aboriginal Employment Strategy to 2022 and the related Aboriginal Employment Action Plan 2019–2022

The Tasmanian State Service Aboriginal Employment Strategy to 2022 aims to support increased representation of Indigenous Australians in the workforce across all sectors, including health. The framework sets a goal of increased workforce participation from 3% to 3.5% by 2022.

This strategy is related to the Aboriginal Employment Action Plan 2019–2022, which outlines key steps to be taken in the first 12 months of its implementation:

- promoting employment to Indigenous graduates
- providing traineeships for Indigenous people
- facilitating workshops that provide information and support Indigenous Australians in applying for positions with the Tasmanian State Government.

ACT Government Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018

The ACT Government Health Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013–2018 supports growth in the Aboriginal health workforce. The aim is to see equal representation of Indigenous and non-Indigenous staff across all areas and streams of health. The key focus areas of the framework include: health workforce development, health workforce leadership, health workforce planning, and health workforce policy.

NT Aboriginal Cultural Security Framework 2016–2026

Two of the key priorities within the NT Aboriginal Cultural Security Framework 2016–2026 are Aboriginal workforce and leadership in the health sector. An aim of the framework is to expand the Northern Territory's health care workforce so that it is representative of the Northern Territory's cultural diversity.

5

Relevant programs and initiatives

5 Relevant programs and initiatives

Several programs and other initiatives have attempted to improve outcomes for Indigenous Australians by focusing either on improving the number and skills of Indigenous health workers or by improving cultural safety for Indigenous workers and people. A summary of this program is provided in Appendix B.

Northern Territory Aboriginal Health Academy

The Northern Territory Aboriginal Health Academy (the Academy) is a traineeship program that started in February 2018. It introduces Indigenous Australian high-school students to careers in allied health, including mental health. The Academy is a strengths-based program that delivers training in a culturally appropriate way. Health is understood within a holistic context of SEWB. During their final year of high school, Academy students are supported into traineeships in local health organisations where they study a Certificate 111 Allied Health Assistance (AMSANT 2020).

Planning and implementation of the program has been a collaboration between Aboriginal Medical Services Alliance Northern Territory (AMSANT), IAHA and local health organisation stakeholders.

Local stakeholders are also seen as critical to the implementation of the Academy model. School and university input builds students' knowledge and understanding of the tertiary sector and possible pathways to employment in health. Mentoring from local Indigenous Australian allied-health workers helps students make informed choices and understand local community and workforce needs.

AMSANT and IAHA recognise that mental health is one area of health where growth in the Indigenous workforce is vitally needed (IAHA 2018). In 2019, IAHA announced $4.65 million in funding from the Australian Government to support the expansion of the Academy model into new regions, including New South Wales, Queensland and the ACT. It is expected that the Academy will support more Indigenous young people to finish their secondary education. It anticipates an expanded and strengthened representation of Indigenous Australians across the allied-health sector as an outcome.

Evaluation

According to AMSANT's 2018–19 Annual Report, an evaluation of the pilot program is currently in progress. Data and evaluation outcomes are not yet available (AMSANT 2019).

High School to Health Careers Program

The High School to Health Careers Program (formerly Rural High School Visits) is a joint initiative of the Northern Territory Primary Health Network (NT PHN) and the IAHA.The program aims to inspire young Indigenous Australians living in rural and remote communities to consider careers in health through school visits from Indigenous health students studying at university or Vocational Education and Training (VET) level.

The students are from around Australia and are studying either medicine, nursing, allied health or the Certificate IV in Aboriginal and Torres Strait Islander primary health care (NT PHN n.d.; Wales 2018). They spend a week touring rural and remote parts of the Northern Territory. In 2018–19, the program visited 250 school children across remote Aboriginal communities, including Maningrida, Elcho Island, Nhulunbuy, Yirrkala and Bathurst Island.

The program aims to strengthening the mental health workforce as local school children hear about the passions and goals of the university students and participate in hands-on activities related to the health disciplines.

Participation in the program will better engage existing tertiary and VET-sector health students with an interest in working in the Northern Territory. It is expected that this immersive hands-on experience will show them the rewards of rural and remote work and reduce the risk of 'culture shock' that can undermine attraction and retention strategies.

Evaluation

No formal evaluation appears to have been carried out, so there are no data available to show the effect of the program on the career decisions of school children in the program.

Feedback from the tertiary and VET-student participants suggests satisfaction with the program is high. Case study data from the NT PHN website (NT PHN n.d.) indicates that students who participate show a strong motivation to return to the remote areas of the Northern Territory once they are qualified. It is difficult to assess the extent to which this translates into action.

Djirruwang Program

In partnership with the NSW Government, Charles Sturt University facilitates the Djirruwang Program. The program is a Bachelor-level course for Indigenous Australians who want to pursue careers in the mental health workforce. Students study a Bachelor of Health Science (Mental Health), but they can exit after completing the Diploma, Associate Degree or full Bachelor program.

The Djirruwang Program led the way in offering clinical mental health training at a tertiary level to Indigenous Australian students. The first Djirruwang Program cohort comprised 5 students in 1994 (Brideson & Kanowski 2004). After gaining accreditation, the program was reshaped into an Associate Diploma and later a Diploma (Grosvenor et al. 2006). The Djirruwang Program was developed further into a degree program and from 2000 onwards, students were able to enrol in the Bachelor course.

The Djirruwang Program has now expanded into 5 jurisdictions in Australia (New South Wales, Victoria, Queensland, Western Australia and the ACT). Western Australia now has an equal number of students enrolled in the program as New South Wales, where it was originally developed.

In 2019, more than 250 students graduated from the program and another 77 new enrolments were received (The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention 2020). 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).

Djirruwang Program External Evaluation

This early evaluation of the Djirruwang Program by Grosvenor et al. (2006) described many positive features, including an emphasis on educating students with cultural respect and a holistic view of mental health.

Enrolled students were invited to anonymously participate in surveys and focus groups. Overall, students reported that restricted entry for Indigenous Australian students was a key positive factor in their decision to enrol. They felt accepted when studying with Indigenous classmates, which contributed to their cultural safety.

The evaluation found the program was under-funded and under-resourced, a concern that was noted by both students and key stakeholders. The evaluation made recommendations for an adequate staffing structure, including a project director (Indigenous).

Stakeholders also reported feeling confused by the program having multiple exit points (Diploma, Associate Degree and Bachelor Degree) because of the uncertainty this created about the capabilities of graduates. The evaluation recommended providing stakeholders with access to clearer information about the qualifications of graduates at each exit point.

Finally, stakeholders suggested Djirruwang Program graduates with a Bachelor of Health Science (Mental Health) should be recognised as having a professional discipline, just as social workers, nurses, and other professional health workers already are.

Cultural safety in Indigenous Health Education

An evaluation by Rigby and others (2010) was based on recruiting focus groups, which identified the program's strengths from the perspective of the students:

- a flexible teaching delivery
- connection to peers
- a sense of ownership of the course
- feelings of empowerment.

Students viewed these qualities as important to supporting their studies and their journey towards joining the mental health workforce.

Other challenges that were identified include the daunting nature of attending a mainstream university and an unfamiliar setting. This related to a key cultural concern of being on new Country. Receiving a Welcome to Country and being introduced to fellow students from diverse Indigenous cultural groups was identified as a way of improving cultural safety for students.

NSW Aboriginal Mental Health Worker Training Program

Through stakeholder interviews and surveys, as well as visits to local health districts and ACCHS, the evaluation by ARTD Consultants and others (2013) found local mainstream health services valued the program. It improved the level of cultural awareness in NSW health services. The capacity of mainstream services to provide access to Indigenous mental health workers and culturally competent services for Indigenous clients was highly regarded.

An ongoing identified limitation of the program has been that students graduate with a Bachelor of Health Science (Mental Health), rather than a clinical qualification such as psychologist, nurse, social worker or occupational therapist (ARTD et al. 2013).

Factors affecting job satisfaction

Cosgrave and others (2017) explored factors related to job satisfaction and employee retention following graduation from the Djirruwang Program. Although the evaluation was limited by participant numbers (n = 5) and geographical location (rural and remote New South Wales), the findings were consistent with informal evidence as well as the broader workforce literature.

The challenges reported by participants included:

- difficulties in feeling accepted in the mainstream workplace
- cultural challenges, such as maintaining boundaries and conflicts of interest within community.

The study noted the importance of mainstream health staff receiving cross-cultural training to understand the cultural challenges faced by Djirruwang graduates and to be able to support their Indigenous colleagues.

Expanded workforce

Expanding the workforce of Indigenous SEWB, mental health and alcohol and drug treatment workers was included in the Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027 (Victorian Government DHHS 2017). The Victorian Budget 2017–18 provided an extra $22 million as an initial investment in an expanded Indigenous Australian mental health and drug and alcohol workforce. This included establishing 10 Aboriginal-specific clinical and therapeutic positions in ACCHS to ensure that ACCHS are able to respond to the demand for social and emotional wellbeing and mental health services.

This initiative aimed to increase the workforce available to deliver culturally responsive, trauma-informed services that can support the SEWB needs of Indigenous Australians living in Victoria.

Additionally, 10 initial trainee positions were created with pathways into the Charles Sturt University Bachelor of Health Science (Mental Health). This 3-year program pays trainees to work under supervision in Victorian health services while they finish their studies. Trainees study by correspondence with the opportunity to secure ongoing employment at their placement organisation when they graduate.

Victoria's Mental Health Services annual report 2018–19

Mental health trainees were recruited from 8 area mental health services across metropolitan and rural Victoria including Eastern Health (2 trainees), Bendigo Health (2 trainees), Alfred Health, Peninsula Health, Latrobe Regional Hospital, Mildura Base Hospital, Monash Health and Forensicare (Victorian Government 2019)

All 10 clinical and therapeutic mental health positions were recruited to selected ACCHS across rural and metropolitan areas. All recruited staff were reported to be qualified clinicians, such as mental health nurses, psychiatrists, psychologists, psychiatric nurses, forensic mental health GPs, and social workers. According to VicHealth these positions are enabling services to deliver trauma-informed SEWB models of care to meet the mental health needs of more than 150 Indigenous Australian clients.

SEWB workforce support units

Some Australian states provide support and professional development to their Indigenous mental health workforce through dedicated workforce units.

Examples of these support units include:

- Queensland Aboriginal and Islander Health Council (QAIHC) Social and Emotional Wellbeing Workforce Development Support Unit
- Social and Emotional Wellbeing Workforce Support Unit Program

- Social and Emotional Wellbeing (SEWB) Workforce Development & Support Unit
- Yorgum Aboriginal Corporation – Workforce Support Unit

These are described in more detail below.

SEWB Workforce Development Support Unit

The Queensland Aboriginal and Islander Health Council (QAIHC) SEWB Workforce Development Support Unit provides professional development opportunities to its members across Queensland—28 Aboriginal and Islander Community Controlled Health Services and Rural Aboriginal and Islander Community Controlled Health Organisations.

For example, a case management workshop for Indigenous health workers was held across 2 days in 2019, canvassing referrals, gathering the client's story, as well as case planning and exit planning.

To assess the training needs of Indigenous health workers in Queensland, the SEWB unit conducts a training needs analysis each year, which was implemented as an electronic survey in 2019. The analysis assessed the needs of an estimated 250 SEWB workers across the Indigenous health workforce (Queensland Aboriginal and Islander Health Council 2020). In doing so, the unit aims to strengthen the Queensland mental health workforce through support and skill development.

SEWB Workforce Support Unit Program

This unit is run out of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and provides professional development and other assistance for Commonwealth-funded Indigenous workers, such as 'Bringing them home' counsellors, alcohol and other drug (AOD) workers, Stolen Generation workers, staff from 'Link-up' Victoria, as well as Koori Mental Health Liaison Officers.

For example, in collaboration with Beyond Blue, the Social and Emotional Wellbeing Workforce Support Unit Program has developed a short film for Indigenous workers about self care. Titled 'Keep yourself healed, Self-care for Aboriginal and Torres Strait Islander Health Workers', it features advice from Indigenous Psychologist Graham Gee. Indigenous health workers in a range of roles share their experiences.

The aim of this unit in relation to strengthening the Indigenous mental health workforce is to empower the Victorian Indigenous community and partners to provide high-quality health services through leadership, support, advocacy and workforce development.

Workforce Development Program and Rural Aboriginal Health Worker Program

Operated by Nunkuwarrin Yunti, the unit's aim is to support a culturally appropriate and competent SEWB workforce in South Australia.

Nunkuwarrin Yunti aims to improve the social and emotional wellbeing of all Indigenous Australians in Adelaide and surrounds and to advance their social, cultural and economic status. It employs a client centred approach to the delivery of its services. It values a collaborative workplace in securing the best outcomes for clients, as well as community control and self-determination.

The unit is funded by the Australian Government to monitor and coordinate professional development training for the SEWB workforce. It also holds regular events to facilitate peer support, networking opportunities, and sharing of knowledge.

Yorgum Aboriginal Corporation – Workforce Support Unit

The Yorgum Aboriginal Corporation – Workforce Support Unit extends training opportunities and support, such as development programs, ongoing training and education as well as debriefing to SEWB workers. It operates in Perth and surrounding areas, including Southwest, Great Southern, Wheatbelt, Goldfields, Midwest, Murchison and Gascoyne regions.

These activities support the organisation's broader objectives, which include providing high-quality counselling services to all Indigenous Australians, as well as working towards positive outcomes for Indigenous people who have been affected by family and sexual abuse.

Evaluation

Although no formal evaluation of the impact of these programs is readily available, providing tailored support to grow the capacity and capability of the workforce is an established approach to professional training, and one welcomed by the Indigenous Australian workforce (Jongen et al. 2019).

Naanggabun Yarning

Naanggabun Yarning is an Aboriginal peer reflection and supervision model and framework model and framework that developed through a process of consultation, research and observational evidence. The purpose of the framework was to provide culturally appropriate supervision training for Indigenous Australian health workers. This included ensuring non-Indigenous mentors were able to provide culturally safe supervision. The framework used a strengths-based approach and cultural ways of learning to enhance Indigenous Australian health workers' wellbeing.

Three programs were developed to train participants in how to use the cultural model and framework:

- peer group reflection
- one-on-one peer reflection
- cultural framework for clinical supervisors of Aboriginal staff.

The aim, following the completion of the project in 2015, was to embed the training in Indigenous organisations in Victoria, making it part of all workers induction to their organisation and to their teams.

Naanggabun Yarning is provided by Nexus, which is part of the Victorian Dual Diagnosis Initiative and located at St Vincent's hospital Melbourne. Their role is to enhance dual-diagnosis capability across the AOD and mental health sectors.

Naanggabun Yarning; Aboriginal Peer Reflection Project

The review by Nexus (2015) found that more than 120 participants completed the training program during 2014 and 2015. Of those, 49 were Indigenous Australians. The majority (75%) were female, and about half of all participants were from regional areas across Victoria.

Feedback about the project from participants was positive, with high levels of satisfaction with both process and content. More than 80% of all participants scored the training in the highest range of 8–10 on all criteria, which included usefulness of the program and how much had been learned.

Pre- and post-training questionnaires suggested that participants had more knowledge and skills as a result of the program. The greatest change was improved knowledge about culturally relevant peer reflection and supervision. Participant feedback validated the cultural relevance of the model and framework, as it was seen as a 'wellbeing tool that should be in all Aboriginal organisations' (Nexus 2015).

RANZCP initiatives

This professional body has several current initiatives to encourage and support the entry of Indiegnous Australians into the field of psychiatry.

One such initiative includes financial support through the provision of grants up to the value of $6,000 annually. The grants are designed to assist Indigenous psychiatry students with specialist training expenses and to support attendance and participation in relevant conferences as well as RANZCP congress events. Attendence is necessary in working towards gaining fellowship. Additionally, RANZCP is accepting applications from Indigenous Australian students for grants to attend workshops that help students prepare for upcoming exams.

As well as supporting its Indigenous trainees, RANZCP has implemented Professor Helen Milroy's (2006) 'The Dance of Life' model into their framework when working with Indigenous clients to improve cultural competence and safety. The Dance of Life Model encompasses an Indiegnous conceptualisation of mental health that includes physical, spiritual, cultural, emotional and social life dimensions. Importantly, the model recognises Indigenous Australian mental health within the context of social determinants and a history of colonisation and collective trauma.

Evaluation

Data to show increases in Indigenous college membership are lacking.

IAHA Mentoring Program

The IAHA Mentoring Program supports Indigenous Australian workers in their professional development journey. It uses webinars, workbooks and one-to-one support. The program allows Aboriginal health workers across Australia to connect with peers and have support, reflect on their practices, and get constructive feedback.

A strengths-based approach is encouraged, with advice provided around how to use techniques such as appreciative enquiry, asset-based thinking, positive psychology, and appreciating and building resilience.

Evaluation

Although there appears to have been no formal evaluation of the program, feedback from participants is positive. The program is based on sound evidence of mentoring approaches that are known to be effective for individual career development. This suggests it supports a strong Indigenous health workforce.

Access to Allied Psychological Services

Access to Allied Psychological Services (ATAPS) exist to provide mental health supports to Indigenous Australians who are unable or have chosen not to engage with ACCHS. Consumers are eligible for a maximum of 12 ATAPS funded sessions per calendar year. The program aims to increase accessibility for all people to short-term psychological support for mental health disorders such as anxiety and depression.

Enhanced Primary Mental Healthcare for Indigenous Australians

This evaluation study by Reifels and others (2018) sought the service implementation strategies and perspectives of providers:

- agency staff such as Medicare personnel
- ATAPS referrers, most of whom were doctors
- mental health professionals delivering services under the ATAPS program.

The study found that 8 of the agencies sought support from Aboriginal health workers from other services when necessary. Another 10 agencies reported not using Aboriginal health workers at all.

In terms of service delivery to Indigenous clients, 2 Aboriginal health workers were reported to have direct involvement.

Perspectives were sought from participants in relation to improving the ATAPS program. A common suggestion was increased flexibility for Indigenous clients, especially in the referral process. Specifically, clients should be able to self-refer or have a referral from their Aboriginal health worker rather than requiring a visit to a GP for a referral.

Flexibility in terms of the session allowance was also requested, as well as a recommendation not to penalise Indigenous clients for 'no-shows' that count towards the sessional limit.

Finally, flexibility around the Indigenous ATAPS provider was suggested as valuable because that would allow Indigenous Australian clients to receive services from a suitably qualified Aboriginal health worker. This would be a change from what is in place currently as the program specifies the provider must be a psychologist, mental health nurse or social worker.

While the study aimed to seek the perspectives Indigenous ATAPS providers, a weakness of the evaluation was the limited inclusion of views from Indigenous stakeholders.

Indigenous Psychology Scholarship Program

Launched in October 2018, the Dr Tracy Westerman Indigenous Psychology Scholarship Program provides eligible Indigenous psychology students with $10,000 per year (full time) to assist with study, living and transport costs. The scholarship gives preference to students with remote and rural connections or those who wish to work in remote and rural locations when they graduate. In the inaugural year, 5 recipients were funded in Western Australia. Since then, the scholarship has expanded beyond its initial focus of Western Australia. In 2020, there were 13 recipients from across the country.

The aim of the program is to increase the number of Indigenous psychologists, by eliminating the financial barrier to studying and providing mentorship from Dr Westerman. No evaluation is yet available for this program.

Indigenous Practitioner Scholarships

In 2020, the Northern Territory Department of Health introduced scholarships for Aboriginal people pursuing careers in health-related disciplines including psychology. Currently, there are 5 scholarship places available, to the value of $5,000 for students in their first year of an undergraduate course.

The department specifically welcomes applications from students aiming to work in the field of mental health as a health professional. Scholarship recipients also have an opportunity to develop their practical experience through 4 weeks of vacation employment with NT Health. This is the first year of the scholarship and evaluation data are not available.

Puggy Hunter Memorial Scholarship

This scholarship is available for Indigenous Australian students studying health at entry level. Areas of study can include Indigenous health work and practice, medicine and psychology (Australian College of Nursing 2020). Full-time students can receive up to $15,000 per year or $7,500 per year for part-time studies. No evaluation data are available for the scheme, but feedback from scholarship recipients is positive.

6

Overarching approaches and best practice

6 Overarching approaches and best practice

Evidence from the above programs and initiatives and the broader research literature suggests that 2 interconnected issues appear to underlie the limited access to mental health services for Indigenous Australians.

- the lack of an Indigenous Australian mental health workforce
- the cultural competence of the non-Indigenous workforce.

Best practice indicates that, if we are to meet the needs of Indigenous Australians, changes are needed at both the individual practitioner level and the broader systems level. Strategies to meet these service gaps include:

- increasing cultural safety through training and systematic changes in the education and workforce sectors
- retaining the current workforce.

Increasing cultural safety

Initiatives to improve cultural safety are critical for adequately meeting the mental health needs of Indigenous Australians. Key strategies for addressing this issue include strengthening the Indigenous Australian workforce and improving the cultural competence of mainstream services.

There are 2 main approaches to addressing both these issues. Both should be underpinned by Indigenous knowledge, leadership and 'ways of doing' by:

- training the existing Indigenous and non-Indigenous workforce
- implementing systemic changes at service and educational level.

Training the existing Indigenous and non-Indigenous workforce

Best practice related to training for the existing Indigenous Australian workforce is described in Section 3 of this paper. As well as the strategies described in that section, on-the-job educational opportunities such as that provided by the Djirruwang Program are also needed.

The value of the Djirruwang Program is that it strengthens the Indigenous workforce by enabling existing practitioners to increase their skills and knowledge though higher qualification. Rigorous and regular evaluation of the program has identified success factors such as:

- feelings of ownership, empowerment and cultural safety stemming from the Indigenous-specific nature of the program
- the flexible teaching methods
- peer-to-peer connections.

Other initiatives to increase access to professional education programs (including scholarships) are also valuable because they increase the available pool of highly trained Indigenous mental health professionals by reducing barriers to education. For example, professional bodies such as RANZCP and AIPA provide funding support for their members.

There is a demonstrated need for training for non-Indigenous mental health workers, especially in relation to the concept of cultural safety. This concept endorses cultural integrity and the promotion of social justice, equity and respect.

The research evidence suggests, however, that health professionals have a limited understanding of the concept of cultural safety (McGough et al. 2018). This is perhaps not surprising given that, traditionally, the roles of mental health professionals have been based on the values and assumptions that reflect the norms of the dominant groups in Western culture. This has resulted in a professional approach that often follows the deficit model that prevails in health disciplines. Overcoming this and moving to a more strengths-based approach requires health services, organisations and government agencies to work with Indigenous Australians. Only then can non-Indigenous health workers understand Indigenous conceptions of SEWB and thus progress strategies—including training packages—that inform and empower staff to practice cultural safety (McGough et al. 2018).

Systemic changes at service and educational level

The evidence also suggests that there is a need to include cultural competence and trauma-informed practice as a key performance indicator in all mental health workplaces. This would ensure that cultural safety is an assessed part of practice rather than a tick- box exercise.

This is a recommendation for ensuring 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 policies should be developed in consultation with Indigenous Australian staff and the local community. The data suggest that only 77% of policies have been informed in this way. Including local workforce and community consultation should be a national requirement so 100% of policies are developed this way. This would encourage mainstream services to engage with local communities and partner with local ACCHS, with the potential to break down barriers and begin to build the trust necessary for increased access to services.

Best practice dictates that all services should have formal arrangements in place to enable systematic access to cultural advice that does not rely on overburdening any individual in the organisation (Cosgrave et al. 2017). These arrangements could be brokered through partnerships with local ACCHS, which would have the advantage of supporting increased Indigenous leadership in mental health services.

A more fundamental approach to ensuring systemic change is the integration of cultural safety into undergraduate curriculums. Including cultural safety and its application to practice in post-secondary health programs links to favourable outcomes for learners, including an increase in the number of Indigenous people entering health education programs and more graduates interested in working in diverse communities (Kurtz et al. 2018).

There is also strong evidence that embedding cultural safety within the curriculum results in improved relationships between practitioners and Indigenous clients. This ultimately results in better health outcomes. More long-term evidence for those benefits is still needed, but it is clear that the curriculum must be developed in partnership with Indigenous people and offered in an environment that is culturally safe for everyone involved. According to (Kurtz et al. 2018:277):

This is a mindful process of navigating and honoring Indigenous and Western perspectives, and what we have learned in our 8 years of delivering an experiential cultural safety curriculum, is that learning is not always comfortable, but if the cultural safety curriculum is offered through a lens of cultural safety, the environment can be transformed into one where people feel safe to teach and learn from each other.

Although it is not specific to mental health training, the Australian Government Aboriginal and Torres Strait Islander Health Curriculum Framework goes some way to addressing this need. It supports higher education providers to implement Indigenous Australian health curriculums across their health professional training programs.

The aim of these curriculums is to prepare graduates across health professions to provide culturally safe health services to Indigenous Australians. It includes an aim to 'embed mandatory cultural competency curriculums, including an understanding of the role of the Aboriginal and Torres Strait Islander Health Worker'. As well as increasing the cultural competency of trainee health professionals, including Indigenous Australian perspectives in curriculums is also expected to increase the respect afforded to Indidengous mental health workers. This will increase recruitment and retention of this sector.

Retaining the current workforce

Addressing cultural safety at the individual and systems level is a strategy focused on the longer-term. The more immediate issue is that of retaining the existing workforce (and therefore current and future leaders). This requires a focus on the wellbeing needs of the Indigenous mental health workforce by supporting Indigenous Australians in their current roles. It is key to successfully expanding and strengthening the mental health workforce.

Tactics to ensure this support include:

- valuing the role of Indigenous mental health workers
- affording greater cultural respect to Indigenous mental health workers
- providing peer support and mentoring.

Valuing the role

Poor workplace attitudes see the contribution of Indigenous mental health workers as less significant than that of other mental health professionals. This leaves Indigenous employees feeling devalued. This type of role devaluation often manifests in restricted and repetitive job tasks. It also results in limited career progression pathways, leading to work-related emotional burden and burn out (Cosgrave et al. 2017).

Access to professional development opportunities and defined career progression pathways increase the sense of being valued. Both of these are vital to job satisfaction and staff retention (Cosgrave et al. 2017). As already discussed, programs aimed at improving career progression options and further training (for example, the Djirruwang Program) go some way to addressing this issue.

Supporting further education and training is not enough unless it leads to opportunities for promotion. There is also a need to remove disparities in remuneration. Without these systemic changes, workers could consider leaving the health sector to find roles in other areas that support their career development goals (Cosgrave et al. 2017).

Greater cultural respect

Along with increased cultural safety, cultural respect is a key dimension to minimising the emotional burden of Indigenous mental health workers. It also is key to addressing the underrepresentation and retention of Indigenous Australians in the mental health workforce (Lai et al. 2018). For instance, Indigenous Australians have cultural obligations to their family and community that could be supported by flexible working arrangements around cultural events and responsibilities (Lai et al. 2018).

Peer support and mentoring

A systematic review of the literature has confirmed the value of peer support and mentorship programs to the experience of Indigenous health workers generally (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.

A research report in the Northern Territory (Aboriginal Resource Development Services Corporation 2015) sought the perspectives of Indigenous mental health workers. It highlighted how people value access to peer support and mentorship within the workplace. Such programs were viewed as important to facilitating reflective practice and creating a support network between junior Indigenous mental health workers and their more experienced counterparts. Opportunities to network with Indigenous mental health workers in roles across the Top End was also identified by Indigenous employees as important to workplace wellbeing.

Workplaces should facilitate peer support, mentorship and supervision that accomodates the challenges faced by Indigenous health workers, which extends professional and personal support (Nelson et al. 2015).

7

Gaps and limitations

7 Gaps and limitations

There are few studies that quantify and highlight the benefits of ACCHS and Indigenous Australian leadership for Indigenous mental health outcomes. Although it is broadly accepted that the perspective of Indigenous Australians is that they experience a greater sense of cultural safety when engaging with Indigenous mental health workers, it should not be assumed that this does not mean an individual does not want to engage with a non-Indigenous worker. 'Ask, don't assume' is seen as the most appropriate way of gauging who might provide the best support in mainstream services (Cosgrave et al. 2017).

More systematic research would help us understand who might be best served by whom and in what circumstances they should be served. This should be a focus of future studies so funding can be appropriately allocated.

There is a lack of both formal and informal evidence of program effectiveness from systematic monitoring and evaluation. This could relate in part to the lack of comprehensive data about matters such as Indigenous Australians access to health services (AIHW 2016). It is essential that we engage in continuous quality improvement of services. This is possible only when data are collected and made available for analysis. This may be addressed in part by the Primary Mental Health Care Minimum Data Set (PMHC MDS) which is intended to provide the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery provided through Primary Mental Health Care Flexible Funding (Department of Health 2019).

There are gaps in the availability of programs specific to mental health. While there could be some worth in generic programs for health and leadership, there could be greater value in developing bespoke programs.

The publication of both formative and summative evaluation of programs is lacking. This could be addressed in the future by the current Australian Government's 'Indigenous Evaluation Strategy' initiative. This initiative aims to develop a whole-of-government evaluation strategy for policies and programs affecting Indigenous Australians. It is anticipated that it will also address another gap, which is the limited extent to which the voice of Indigenous Australians can be heard in the evaluations of Indigenous programs and policies.

If we are to understand the value and usefulness of programs and policies, we must hear about their impact from those who are expected to benefit. Without this, there is no self-determination and limited if any opportunity to ensure improved outcomes for Indigenous Australians.

Finally the distributed nature of the evidence in relation to this topic should be noted. There are 2 issues here:

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

A more systematic and national approach to logging policy and program is needed. This efficiency would enable better access to the evidence, while ensuring that relevant mental health issues were addressed at the local level in all jurisdictions. The advice and leadership of Gayaa Dhuwi could deliver the focus, knowledge and understanding at a national level. This would enable a more systematic approach to providing the support and training needed to strengthen and expand the mental health workforce so no one is left behind.

8

Conclusions

8 Conclusions

The available evidence suggests that poor access to mental health and suicide prevention services are associated with mental health workforce deficiencies in 2 primary ways:

- A lack of Indigenous-led services due to workforce shortages means Indigenous Australians cannot access preferred services.
- There is a reluctance to access existing services due to their limited cultural safety.

This goes beyond the issues around mainstream services that lack cultural safety. The difficulties in recruiting and retaining appropriately qualified Indigenous Australians to ACCHS also puts these services at risk of a lack of cultural safety.

Evidence-based strategies to tackle these workforce issues must be based on all of the following 3 factors working together:

- increasing cultural safety through training and education
- systemic changes at the health service and educational level to embed cultural competency in the work place and professional training
- strategies aimed at retaining the existing workforce, for example through increasing the extent to which ATSIMHW are valued, respected and supported in the workplace.

Although approaches aimed at expanding and strengthening the Indigenous mental health workforce are an important component of improving mental health outcomes for Indigenous Australians, they must be considered within a much broader social context.

For example, the aim of providing culturally safe mental health services with a full complement of staff, whether in mainstream services or ACCHS, will improve the mental health of Indigenous Australians only if there is full trust, knowledge and understanding of what the service can offer.

The broad evidence about access to health care is clear. Providing well-run, fully-funded services is not enough alone to ensure access. Access to health care is a function of social and cultural knowledge, norms and expectations. Without a complementary program of education about the role and benefits of mental health services—including Indigenous Australian worldviews of SEWB—an expanded and strengthened workforce cannot improve mental health outcomes for Aboriginal people and Torres Strait Islanders.

Appendixes

Appendix A: Policies and frameworks

Table A1. Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023	This framework is intended to guide and inform Indigenous mental health and wellbeing reform (Department of Prime Minister and Cabinet 2017). It provides a framework for action in response to the high incidence of social and emotional wellbeing problems and mental ill-health.	ACTION AREA 1 – Strengthen the Foundations Outcome 1.1: An effective and empowered mental health and social and emotional wellbeing workforce.	Gayaa Dhuwi, the current leadership group for Indigenous mental health and SEWB in Australia, is responsible for steering implementation. In 2017–18, 68% of all Indigenous Primary Health Services reported SEWB as a gap in service delivery (AIHW 2019a).
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	The strategy's objective is 'to reduce the cause, prevalence and impact of suicide on individuals, their families and communities' (Department of Health 2013). It was informed by extensive Indigenous community consultation across Australia.	Goal 4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels Action area 6: Standards and quality in suicide prevention. Component 1) Measures to improve Aboriginal and Torres Strait Islander participation in the workforce through access to training and qualifications at all levels	

(continued)

Table A1 (continued): Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023	The Framework aims to contribute to the achievement of equitable health outcomes for Aboriginal and Torres Strait Islander people through building a strong and supported health workforce that has appropriate clinical and non-clinical skills to provide culturally-safe and responsive health care.	Strategy 1: Improve recruitment and retention of Indigenous health professionals in clinical and non-clinical roles across all health disciplines Strategy 2: Improve the skills and capacity of the Indigenous health workforce in clinical and non-clinical roles across all health disciplines Strategy 3: Health and related sectors be supported to provide culturally-safe and responsive workplace environments for the Indigenous workforce Strategy 4: Increase the number of Indigenous students studying for qualifications in health Strategy 5: Improve completion/graduation and employment rates for Indigenous health students Strategy 6: Improve information for health workforce planning and policy development	There were 863 registered and practising Indigenous health professionals at 31 December 2020 (AHPRA 2021) In 2017–18, 71% of all Indigenous primary health services expressed challenges in recruiting, as well as providing appropriate training and support to Indigenous Australian staff (AIHW 2019a). Indigenous Australians made up 54% of Commonwealth funded Indigenous primary health care workforce at June 2018 (AIHW & NIAA 2020). Within ACCHS, Indigenous people fill the majority of Indigenous health practitioner (85.2%) and Outreach worker (84.3%) positions (AIHW & NIAA 2020). Indigenous administrative staff are the most numerous (AIHW & NIAA 2020). In addition, at least half the administrative staff are Indigenous (52.1%) and almost half are in senior management positions (47.2%) (AIHW & NIAA 2020).

(continued)

Table A1 (continued): Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
The Aboriginal and Torres Strait Islander Health Curriculum Framework	The aim of the Framework is to provide a model for higher education providers to successfully implement Indigenous curricula, with clear learning outcomes and associated capabilities that could be applied widely across tertiary learning contexts.	Core principles guide the Framework overall and provide the context for successful implementation. They also outline the necessary graduate cultural capabilities. The Framework provides resources, suggestions, tools and guidelines to assist higher education providers implementing the framework.	
Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health	Embedding cultural respect, through cultural safety and responsiveness, into the design, delivery and evaluation of health services support the development of a diversely skilled and dynamic workforce.	Domain 3: Workforce development and training • Indigenous workforce • Indigenous leadership • Culturally responsive heath workforce	

Appendix B: Programs

Table B1: Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details	Outcomes
The Northern Territory Aboriginal Health Academy This is a traineeship that introduces Indigenous Australian high-school students to careers in allied health, including mental health. It aims to support more Indigenous Australian's to complete high school and further, to promote allied-health careers to young Indigenous Australians. The program commenced in the Northern Territory in 2018, with funding received to expand into new regions, including New South Wales, Queensland, and the ACT.	Location(s)	Northern Territory, New South Wales, Queensland, ACT	None available	N/A	According to AMSANT's 2018–19 Annual Report (AMSANT 2019), an evaluation of the pilot program is currently in progress.
	Participants	In 2018, 24 senior high-school students were the first cohort to join the Academy			
	Duration	1 year			
	Indigenous specific	No			
High School to Health Careers Program (Northern Territory) Local schoolchildren in rural and remote communities are visited by university students from around Australia, who are enrolled in allied-health courses. The aim is to inspire young people living in rural and remote communities to consider careers in health and to promote careers in rural and remote settings.	Location(s)	Northern Territory	None available	N/A	Evaluative data are not readily available.
	Participants	In 2018, 250 school children were visited by 6 university students			
	Duration	1 week			
	Indigenous specific	No			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details	Outcomes
Djirruwang Program In partnership with the NSW Government, Charles Sturt University facilitates a Bachelor of Health Science (Mental Health) for Indigenous Australians wanting to pursue careers in the mental health workforce.	Location(s)	New South Wales, Victoria, Western Australia, Queensland, the ACT	Limited evaluative data are available, but the following reports provide some insight into outcomes. Cosgrave et al. (2017) Factors affecting job satisfaction of Aboriginal mental health workers in community mental health in rural and remote New South Wales. ARTD Consultants et al. (2013) Evaluation of the Aboriginal Mental Health Worker Training Program Rigby et al. (2010) The Djirruwang Program Grosvenor et al. (2006) Djirruwang Program External Evaluation		Local health services value the program and report it increases cultural competence within mainstream services. It is challenging for graduates to feel accepted within mainstream workplaces. Cultural challenges for graduates include maintaining boundaries and conflicts of interest within community. In 2019, 250 students graduated from the program and 77 new enrolments were received. A recurring concern for graduates is unequal remuneration, because students do not graduate with one of the designated case management clinical qualifications (nurse, psychologist, social worker, occupational therapist).
	Participants	250 in 2019			
	Duration	3 years (Bachelor) or earlier exist at Diploma and Associate Degree levels			
	Indigenous specific	Yes			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details	Outcomes
Expanded Workforce – Aboriginal social and emotional wellbeing, mental health and alcohol and drug treatment (Victoria) The Victorian Budget 2017–2018 provided an additional $22 million as an initial investment into an expanded Indigenous Australian mental health and drug and alcohol workforce. Ten Aboriginal-specific clinical and therapeutic positions in ACCHS were created and recruited to, as well as 10 traineeships with pathways into the Charles Sturt Djirruwang Program.	Location(s)	Victoria	No formal evaluations are available; however, the 2018–19 Annual Report provides updates		Both the clinical staff and traineeship projects were successfully recruited across 8 area mental health services in metropolitan and rural Victoria.
	Participants	120 in 2014–15			
	Duration	3 years			
	Indigenous specific	Yes			
	Focus	To increase the workforce available to deliver culturally responsive, trauma-informed services that can address the SEWB needs of Indigenous Australians living in Victoria			
Queensland Aboriginal and Islander Health Council (QAIHC) Social and Emotional Wellbeing Workforce Development Support Unit The program provides professional development opportunities to its members: 28 Aboriginal and Islander Community Controlled Health Services (AICCHS and Rural Aboriginal and Islander Community Controlled Health Organisations (RAICCHO) across the state.	Location(s)	Queensland	None available		No evaluative information is available.
	Participants	28			
	Duration	N/A			
	Indigenous specific	Yes			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Outcomes
Naanggabun Yarning: Aboriginal peer reflection and supervision model and framework The model and framework were developed to provide culturally safe supervision training for Indigenous Australian health workers. Three programs were developed to train participants in how to use the cultural model and framework: • Peer group reflection (2 days) • One-on-one peer reflection (3 days) • Cultural framework for clinical supervisors of Indigenous Australian staff (2 days).	Location(s) Participants Duration Indigenous specific	Victoria 120 in 2014–15 N/A Entirely Indigenous for Peer group reflection and One-on-one peer reflection. Non-Indigenous workers could participate in Cultural Framework for clinical supervisors of Aboriginal staff	NEXUS (2015) Naanggabun Yarning; Aboriginal Peer Reflection Project Pre- and post-training evaluation using Likert scales: • how satisfied people were with the training • how stimulating • how useful • how well discussions flowed • how well it was conducted • how the pace of the training matched the group's needs • how much they learned • how highly would they recommend it to others.	Location(s) Participants Duration Indigenous specific	Victoria 120; 75% women, 50% from regional Victoria Not stated Not stated	High levels of satisfaction with both process and content. 95% in all three training groups said they would highly recommend training 92% found it very useful and were very satisfied with the training The greatest growth occurred in people's knowledge about culturally relevant peer reflection and supervision
Workforce Development Program and Rural Aboriginal Health Worker Program (South Australia) This program provides support, networking and advocacy for Indigenous health workers across South Australia.	Location(s) Participants Duration Indigenous specific	South Australia 12 Indigenous health workers Ongoing Yes	None available			No program evaluations are readily available

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details	Outcomes
Yorgum Aboriginal Corporation – Workforce Support Unit (WSU) The WSU extends support to social and emotional wellbeing workers within Perth and surrounding area.	Location(s)	Western Australia	None available		No program evaluations are readily available.
	Participants	Not available			
	Duration	Ongoing			
	Indigenous specific	Yes			
RANZCP Initiatives This professional body has several current initiatives to encourage and support the entry of Indigenous Australians into the field of psychiatry. Initiatives include financial support for training and exam preparation workshops.	Location(s)	Australia and New Zealand	No formal program evaluations are readily available however, RANZCP provides some data		According to a RANZCP report in 2014, there was an increase in the number of trainees intending to work with Australian Indigenous and/or Maori populations as a speciality area (8% in 2011 to 15% in 2015). However, there is no indication as to whether this workforce was of Indigenous heritage. In addition to grants, RANZCP has implemented 'The Dance of Life' model into their framework when working with Indigenous clients. The Dance of Life model encompasses an Aboriginal conceptualisation of mental health and importantly, recognises Indigenous Australians' mental health within the context of social determinants and a history of colonisation and collective trauma.
	Participants	Not available			
	Duration	Ongoing			
	Indigenous specific	No			

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details	Outcomes
Social and Emotional Wellbeing Workforce Support Unit Program This unit, run out of VACCHO, supports Commonwealth-funded Aboriginal Workers, such as 'Bringing Them Home' counsellors, AOD workers, 'Stolen Generation' workers, staff from 'Link-up' Victoria, as well as Koori Mental Health Liaison Officers.	Location(s)	Victoria	None available		No program evaluations are readily available.
	Participants	Not available			
	Duration	Ongoing			
	Indigenous specific	Yes			
IAHA Mentoring Program The IAHA Mentoring Program supports Indigenous health workers with their professional development journey, allowing workers across Australia to connect with peers.	Location(s)	National	None available		No program evaluations are readily available; however, the program is based on sound evidence of mentoring approaches that are known to be effective for individual career development and feedback from participants is positive.
	Participants	Not available			
	Duration	Ongoing			
	Indigenous specific	Yes			
	Focus	A strengths-based approach whereby advice is provided around how to use techniques such as appreciative enquiry, asset-based thinking, positive psychology and appreciating and building resilience			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Outcomes
Access to Allied Psychological Services (ATAPS) Program ATAPS services exist to provide mental health supports to Indigenous Australians who are unable or have chosen not to engage with ACCHS. Consumers are eligible for a maximum of 12 ATAPS funded sessions per calendar year.	Location(s)	National	Reifels et al. (2018) Enhanced primary mental health care for Indigenous Australians: service implementation strategies and perspectives of providers Semi-structured interviews with service providers	Location(s)	Not stated	Eight out of 31 service providers reported they sought support from Aboriginal health workers from other services when necessary. Ten services reported not using Aboriginal health workers at all. Perspectives from participants focused on the need for increased flexibility—clients be able to self-refer, Aboriginal health workers be able to refer clients and for Aboriginal health workers to be able to provide ATAPS services. Additionally, loosening of penalisation for 'no-shows'.
	Participants	In 2014–15, 71,830 referral uptakes (87,128 referrals)		Participants	Semi-structured interviews with 31 service providers • 18 ATAPS administering agency staff • 5 ATAPS referrers • 8 mental health professionals delivering Indigenous ATAPS	
	Duration	Ongoing		Duration	Not stated	
	Indigenous specific	No		Indigenous specific	No; focused on training provider, referrers & administrators	

Appendix C: Methods

A rapid review processes was used to identify, synthesise and evaluate the current evidence around Indigenous workforce development, particularly in regard to mental health services. This entailed:

- purposeful search of electronic databases such as PubMed, Ovid Medline, PsycINFO, Web of Science, ATSIhealth, Australian Indigenous HealthInfoNet
- search of relevant government department websites
- general internet search to ensure any program evaluations published on the web, but not necessarily in academic journals
- critical appraisal to determine the quality and relevance of the research and evaluation evidence.

The rapid review concentrated on publications:

- from the preceding 10 years
- written in English
- relating to the Australian context.

Evidence from outside of the Indigenous Australian context was assessed for relevance and applicability to the Indigenous Australian workforce.

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Abbreviations

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
ACT	Australian Capital Territory
AICCHS	Aboriginal and Islander Community Controlled Health Services
AIHW	Australian Institute of Health and Welfare
AIPA	Australian Indigenous Psychologists Association
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	alcohol and other drugs
ATAPS	Access to Allied Psychological Services
ATSIHW	Aboriginal and/or Torres Strait Islander Health Workers
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
GP	General Practitioner
IAHA	Indigenous Allied Health Australia
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal and/or Torres Strait Islander Health Worker Association
NATSILMH	National Aboriginal and Torres Strait Islander Leadership in Mental Health
PHN	Primary Health Networks
NT PHN	Northern Territory Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
RAICCHO	Rural Aboriginal and Islander Community Controlled Health Organisations
RANZCP	Royal Australian and New Zealand College of Psychiatry
SEWB	Social and emotional wellbeing
SNAICC	Secretariat of National Aboriginal and Islander Child Care
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VET	Vocational education and training
WSU	Workforce Support Unit

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While Aboriginal and Torres Strait Islander people feel more culturally safe in services delivered by Indigenous mental health workers, they are underrepresented in the mental health workforce. This publication reviews the evidence of what works to improve the retention and advancement of Aboriginal and Torres Strait Islander mental health workers.

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