



# The struggle for systematic 'adulthood' for Aboriginal Mental Health in the mainstream: The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program

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## Abstract

The title of this paper refers to issues of growth, development and maturity in Aboriginal Mental Health as it emerges as a specialised profession in the mainstream mental health system. The paper raises many challenges to the existing mental health structures. It asks a number of key questions regarding the professional status of Aboriginal Mental Health Professionals operating in the mainstream mental health industry. The paper describes the approach the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program is taking to ensure that its students graduate with all the necessary skills, attitudes, knowledge and values to be effective professionals in their own right. It highlights the collaboration required by the mental health industry to ensure that the entire mental health workforce and the services in which they operate create a supportive environment for the development of the Aboriginal and Torres Strait Islander mental health workforce. Finally it seeks the support of the mental health industry and professional organisations to move towards systematic adulthood with respect to 1) the professional recognition of students and graduates of the program, and 2) the need for professional organisations, and service management and staff to take responsibility in their responses to Aboriginal mental health issues. The need to effectively deal with the above workforce issues is based on the evidence that Aboriginal and Torres Strait Islander people suffer from higher levels of emotional distress and possible mental illness than that of the wider community. Suicide and self-harm rates are also considerably higher in comparison to that of the broader population (AIHW, 2001). Surely, if there is a higher level of identified need there must also be a higher level of orchestrated effort required.

## Keywords

*Aboriginal and Torres Strait Islander mental health, education, workforce development*

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### **Brief History of the Djirruwang Program**

The Djirruwang Program delivers a three-year Bachelor of Health Science (Mental Health) Degree (see Table 1) with exit points at Degree, Diploma and Certificate levels. Course entry is restricted to Aboriginal and Torres Strait Islander people. The Program commenced in November 1993. In 2004, there are 46 students from across Australia studying in the course. Since commencement the program has contributed significantly to the mental health workforce. Seventy students have graduated from the course (34 with degrees, 35 with diplomas and one with a University Certificate).

The Course was initially developed in a collaborative process between the mental health services and Aboriginal people. In 2002 a process was undertaken to revise the curriculum and course structure. This was completed under the direction of a National Reference Group consisting of a range of representative stakeholders from the mental health industry, Aboriginal community controlled sector, and the education sector including Charles Sturt University.

The curriculum was reviewed and rewritten where appropriate. The process was undertaken by Aboriginal and non-Aboriginal people from the mental health industry. The course is delivered by Aboriginal and non-Aboriginal mental health professionals as well as university lecturers.

### **The Djirruwang Program response to the policy context**

In regard to curriculum development and the longer term directions, the Djirruwang Program has consistently aligned itself with broader developments in the Aboriginal and Torres Strait Islander health and mental health arenas. These developments stress the need for an effective professional workforce, quality training and building the capacity of services that are ultimately responsible for the delivery of health care needs. In particular the program has taken extreme care to remain consistent with the following mental health policy directions, and broader health industry policies and initiatives:

- *National Practice Standards for the Mental Health Workforce* (Commonwealth Department of Health and Ageing, 2002)

- *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments* (National Aboriginal and Torres Strait Islander Health Council, 2003)
- *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002)
- *The National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004 – 2009* (Australian Health Ministers' Advisory Council, 2004)
- *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003)
- *National Standards for Mental Health Services* (Australian Health Ministers' Advisory Council, 1997)
- *RANZCP Position Statement #50, Aboriginal and Torres Strait Islander Mental Health Workers* (Royal Australian and New Zealand College of Psychiatrists, 2002)
- *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health* (Swan & Raphael, 1995)
- *NSW Aboriginal Mental Health Policy* (NSW Health Department, 1997)

The Djirruwang Program is the first in Australia to respond to the *National Practice Standards for the Mental Health Workforce* in terms of curriculum and competency development. The program suspects it also precedes the mental health industry's application of the agreed generic mental health clinical practice standards, at the professional and service level.

### **Context to the Djirruwang Program approach**

The Program has incorporated the National Practice Standards into the curriculum to ensure it is producing graduates with consistent skills, knowledge, values and attitudes of like-minded mental health professionals, whilst maintaining a deep sense of cultural integrity. The program has always had a strong history of clinical competence linked to education delivery, dating back to 1994 (Kanowski & Westerway, 1996). At the time these competencies were innovative and formalised through the university and individual health services. The release of the National Practice Standards gave the opportunity to link these previous competencies with the agreed industry standards for the mental health workforce.

**Table 1. The Djirruwang Program: Course structure by semester, year and mental health clinical activity (mental health professionals deliver the course content in most subjects)**

	Year One	Year Two	Year Three
<b>Semester One</b>	Generic Skills in Mental Health	Aboriginal Mental Health and Wellbeing 2	Research in Mental Health (year long)
<b>Autumn</b>	Health Promotion	Gender and Mental Health	Healing our People (Counselling 2)
	Aboriginal Mental Health and Wellbeing 1	Diagnosis and Management in Psychiatry 1	Sexual Assault
	Introduction to Mental Health	Crisis Management 1	Mental Health and Substance Use (Dual Diagnosis)
<b>Semester Two</b>	Healing our People (Counselling 1)	Ageing and Mental Health	Research in Mental Health (cont.)
<b>Spring</b>	Healing our Spirit: Grief and Loss	Forensic Mental Health	Child and Adolescent Mental Health
	Working with Families	Crisis Management 2	Family Violence
	Substance Use: Assessment and Management	Diagnosis and Management in Psychiatry 2	Professional Issues in Aboriginal Mental Health
<b>Total Yearly Clinical Placement</b>	Clinical Placement 4 weeks	Clinical Placement 8 weeks	Clinical Placement 8 weeks

**Box 1. Bachelor of Health Science (Mental Health) Course Objectives**

The objectives of the Bachelor of Health Science (Mental Health) course are to provide high quality mental health information and experiences for students to:

- ensure Aboriginal and Torres Strait Islander people have the opportunity to participate in high quality tertiary education in the field of mental health;
- contribute to the creation of a highly skilled and effective Aboriginal and Torres Strait Islander mental health workforce;
- be consistent with and demonstrate competence in the recognised National Practice Standards for the Mental Health Workforce;
- provide safe, effective mental health care, as a beginning mental health practitioner, for individuals and groups across the age continuum in a variety of health care settings;
- respond appropriately to the context in which mental health care occurs;
- apply scientific and social science knowledge to the provision of mental health care;
- have an appreciation of the cultural, psychological, physical, social, environmental, spiritual and political factors impacting on people experiencing mental health issues;
- appreciate the importance of research in building mental health evidence;
- have an awareness of the extent to which personal values and beliefs may impact on mental health care;
- undertake responsibility for personal professional development and self evaluation; and
- demonstrate the generic skills of graduates of Charles Sturt University and the Faculty of Health Sciences. (Kanowski & Brideson, 2003)

## **Box 2. Djirruwang Aboriginal and Torres Strait Islander Mental Health Program – *Clinical Handbook and Course Competencies* summary**

The Djirruwang Program's *Clinical Handbook and Course Competencies 2003*, document was developed at Charles Sturt University by the Bachelor of Health Science (Mental Health) course. The document was developed by Kanowski and Brideson (2003) with the valuable assistance of a development team comprising Aboriginal and Non-Aboriginal mental health professionals (see acknowledgements). The *National Practice Standards for the Mental Health Workforce, 2002*, are successfully incorporated into the document.

Importantly, in the developmental stages of the *Clinical Handbook and Course Competencies* document, the Aboriginal and Torres Strait Islander students studying for the Bachelor of Health Science (Mental Health) in 2002/03 unanimously supported the need to be consistent with developments in the mental health industry. It is intended the document will improve collaboration between industry stakeholders and students who are seeking formal university qualifications. The Djirruwang Program believes this development will be a significant contribution to the mental health industry.

### **Application**

The *Clinical Handbook and Course Competencies* document works in a very simple process by linking theoretical learning to clinical experience and clinical practice. This makes the application of skills immediately relevant and applicable. All clinical activity is agreed upon between students and the mental health industry under a formal learning agreement. As with all previous course competencies, the levels of competence are signed off by clinical supervisors from the mental health industry. The inclusion of the *National Practice Standards* into the course means the mental health industry will take a more formalised lead role in contributing to the building of an efficient, effective and clinically trained Aboriginal and Torres Strait Islander mental health workforce. This information was communicated in a background paper and presentation and then agreed to by all NSW Area Health Service, Directors of Mental Health at their regular forum conducted by the NSW Centre for Mental Health in May 2003 (Brideson, 2003).

### **Requirements**

Students of the program are required to undertake a minimum of 20 weeks of clinical placement throughout the duration of their studies. The duration of 20 weeks was to be consistent with similar professions working in mental health. Each year students complete the bulk of their clinical activity within mainstream mental health services. Students also undertake placements within Aboriginal Medical Services and drug and alcohol services. This is designed to provide a broad perspective on issues that impact of people's mental health - not simply the diagnostic criteria without the cultural and social context.

### **Uses**

The *Clinical Handbook and Course Competencies* aims to prepare students to develop the appropriate knowledge, skills, attitudes and values to work at the beginning practitioner level in a mental health setting. The competencies reflect the specialist nature of Aboriginal and Torres Strait Islander mental health work as well as reflecting the core skills required of all members of the mental health and alcohol and other drug workforce.

### **Clinical placement objectives**

The objectives of the clinical placements are to provide students with the opportunity to interact with people experiencing mental and substance use disorders and their families/carers and to develop and extend the skills learned in the theoretical program. The placements are also important learning environments to assist students to develop and refine the necessary interpersonal and clinical skills required during their professional careers. Important areas covered include working directly with people in a clinical environment and to develop an understanding of legal and ethical issues associated with clinical practice. These objectives are designed to assist students in their transition from their role as a student to their role of competent and safe beginning practitioner.

Some quarters of the mental health industry suggest that students and graduates of the program are not equipped with the ability to perform within a clinical role. One of the reasons (as with any professional group) is that it may well be the individual qualities of the worker rather than the quality of education as the problem. It may be the lack of support, training or clinical supervision provided by the mental health industry that could have contributed to the

worker not performing to the service's desired standard in a clinical role. Interestingly, not all professionals are necessarily good clinical workers upon graduation. Comments like these make one wonder why there is a reference that the university training is the issue. Would this mean when a member of another profession performs poorly during their careers that their university course is responsible? Absolutely not!

Another anecdotal comment floating through the industry is that the graduates are not qualified counsellors. Could this comparison now suggest that other workers in the mental health field are not counsellors? No. These are simply absurd ways of some industry people attempting to devalue the status of Aboriginal students and graduates. For all these reasons the program has ensured that the course structures and processes meet with the mental health industry's own blueprint for effective clinical practice.

### **Clinical supervision responsibilities**

It is important for the reader to know where the responsibilities lie in the development of the clinical skills in a mental health setting. Most of the students or graduates referred to in the issues above are or were employed by the workplace as Aboriginal Mental Health Trainees and then supported by the workplace to enrol in the Bachelor of Health Science (Mental Health). The purpose of undertaking formal studies is to understand the theoretical components that complement clinical practice. The workplace still provides the venue and is responsible for clinical experience, clinical supervision and clinical skill development at the service level. This has been the approach the Djirruwang Program has taken since it first commenced in 1994. Further to this, other mental health professionals are not expected to graduate from a course and then hit the ground running in the area of mental health. There is support provided to them to ensure they are equipped to function effectively within a mental health setting. So the mental health industry needs to think about similar principles in regard to graduating students from Aboriginal mental health courses such as the Djirruwang Program. There exists the attitude that Aboriginal people are expected to be automatic experts either during training or at the end whereas some other professions for example have a period of supervised clinical practice.

Professionals and management who are territorial with their discipline specific fortresses are laying down a minefield for students and graduates to navigate. As professionals there is a need to recognise that this attitude is contributing to people deserting the industry for more lucrative and less stressful environments. In order to compete with this territorial theory of

colonialism maybe Aboriginal Mental Health Professionals need to apply similar rules by creating a new professional discipline to work under – to consider the privileges of collective bargaining across awards and professional status. The responsibilities of services and professions need to reflect the general attitudes they have towards Aboriginal Mental Health as a growing profession rather than simply a patronising response. Such a response can be demonstrated by examining the factors inherent in the *Seasonal Work Syndrome* (Brideson, 2003, 2004).

The Royal Australian and New Zealand Congress of Psychiatrists produced a position statement in 2002 clearly outlining the issues for Aboriginal and Torres Strait Islander Mental Health Workers (RANZCP, 2002). A paper presented to the Congress by Brideson in 2003 outlined the need to move beyond the *Seasonal Work Syndrome* in the mental health system in regard to Aboriginal mental health.

This definition (Brideson, 2003, 2004) may explain the concept:

*'People who work in positions that are responsible for limited tasks and specific time limited roles in the workplace that are:*

- a) generally viewed upon by others as being much less important, and/or,*
- b) made to feel that their role is much less important than other 'real professions'.*

*Seasonal Work Syndrome* is a very simple concept that implies Aboriginal and Torres Strait Islander people are employed in some instances as cheap labourers to perform the menial tasks that services and professions are reluctant to or possibly unable to perform. Similarly, the notion of 'seasonal work' relates to the farmer who employs unskilled labourers to pick fruit or to chip cotton for a cheap price. (This fictitious syndrome is explored in more detail in a guest editorial in this issue - [see Brideson, 2004.](#))

### **Professional recognition**

As the course is consistent with the mental health industry's own blueprint for practice, the intention is to set the platform of a recognised professional clinical qualification nationally for Aboriginal and Torres Strait Islander graduates of the course. Professional recognition is currently inconsistent within services and across

each State and Territory. This situation is unacceptable and requires serious consideration particularly given the inclusion of the industry blueprint for clinical practice.

There is no doubt that the Djirruwang Program offers the most comprehensive set of practical and theoretical skills of any undergraduate mental health course in Australia. Whilst the five major professions offer components applicable to the mental health field at an undergraduate level, all course materials and clinical activity included in the Djirruwang Program relates specifically to mental health and wellbeing (refer to Table 1). This situation alone is compelling justification for the national recognition of the graduates of the Djirruwang Program. These are important issues that require the urgent consideration and the support of the mental health industry as Aboriginal people search for a welcoming party that may begin to consider them as equals with the same level of professional standing other mental health disciplines currently enjoy. This reflects a move towards the issue of 'adulthood' that is urgently required by the mental health industry.

This development however does not mean the Aboriginal or Torres Strait Islander mental health professional is required to leave their cultural identity at the door of a mental health service. The underlying philosophy of the Djirruwang Program promotes mental health learning in the context of cultural identity. This means that students are respected as cultural brokers in order to make sense of the mental health industry and to apply their learning to the cultural context. This may mean that services need to reconsider their current approach and work within the context of the issues outlined in the Position Paper by the Royal Australian and New Zealand Congress of Psychiatrists in 2002. As with the spirit of the *National Standards for Mental Health Services* (Australian Health Ministers Advisory Council, 1997) diversity should be considered an asset or at least, core business, in the management and delivery of an effective mental health service. It should not be considered a simple policy response or something additional or 'special' by the mental health industry.

### Why restricted entry?

The issue as to why the course has restricted entry to Aboriginal and Torres Strait Islander people requires explanation. The answer to this is very simple. The Djirruwang Program is in the business of creating an effective and efficient Aboriginal and Torres Strait Islander mental health professional workforce. Program staff are committed to ensuring that student's have opportunities to learn in a safe environment and have input to their learning in a culturally appropriate manner. There is overwhelming information about education systems and their treatment of Aboriginal and Torres Strait Islander people. If services and professional groups are to assist and be committed to the creation of the Aboriginal mental health workforce as a valued and essential component of the mental health system the issue of restricted entry should be promoted, not questioned.

The fact remains that the broader mental health workforce and services are ill equipped to respond to specific population groups with complex needs. This was clearly communicated in the *International Mid-Term Review of the Second National Mental Health Plan* (Thornicroft & Betts 2002). Some of the population groups identified were people of Aboriginal and Torres Strait Islander backgrounds, people experiencing issues of dual diagnosis and people with forensic mental health issues. This is a major concern to the training that professionals are receiving from their professional organisations or the broader education system. All professional groups should be questioning their professional organisations as to why their educational institutions have failed to provide them with the necessary knowledge, skills and attitudes to effectively address the specific needs of these population groups. Perhaps professionals should be seeking the urgent attention of their relevant organisations to assist in identifying strategies to overcome this predicament. However there is a more serious issue to consider. That is the concern that the mental health services may not be effectively operating in accordance with the *National Standards for Mental Health Services*.

The final reason for restricted entry is that given the territorial fortresses, there is the risk of

potentially end up creating a whole new group of people as 'experts' in Aboriginal issues who know what is best for Aboriginal people. Unfortunately this has been seen before with disastrous outcomes. Take for example the protectionist and assimilationist policies. This is one of the main reasons Aboriginal people are in the mental health arena in the first place and are still dealing with the impact of a shared history and past policies and practices. There is a further risk of having Aboriginal identified positions in mental health services replaced by people with 'expert' theoretical knowledge who completely lack the application to the cultural context. The education and training of the professions or the workplace is therefore not the responsibility of the Djirruwang Program. It is strongly suggested that professional education issues be taken up directly with health service management and professional organisations. Aboriginal people have enough on their plates in dealing with the higher levels of emotional distress in their communities. For all the reasons identified above it has the potential to fail to acknowledge students and graduates of the Djirruwang Program as valued and welcome in the workplace.

### **Linking with professional pathways**

The five mental health professional groups have generally been slow to establish pathways into their professional fortresses for Aboriginal and Torres Strait Islander people. There are probably many reasons for this. These reasons certainly require further investigation and discussion. Regardless, the Djirruwang Program is very keen to establish dialogue on how students and graduates can dovetail into these mental health professions and how appropriate credit transfer arrangements can be established with the view to increasing the numbers of Aboriginal and Torres Strait Islander people in these professional groups. The Djirruwang Program sees this as very necessary across the area of mental health given the limited numbers of Aboriginal and Torres Strait Islander people with qualifications in these five disciplines (Wenitong, 2002, Ch. 6). The Program is offering an opportunity that may work if the transfer arrangements across disciplines are suitably recognised. Certainly the inclusion of the industry practice standards opens the door for these opportunities to be

explored. Certainly a number of students have indicated interest in these professional pathways.

### **Conclusion**

If the Aboriginal mental health workforce is allowed to grow into a valued, respected and essential component of the workplace those people occupying the professional positions will provide the cultural context to the workplace. The inclusion of the National Practice Standards into the program has provided a vehicle to establish equivalence as professionals in their own right and to move into 'adulthood' in respect to mental health service delivery.

The incorporation of the National Practice Standards (endorsed by all mental health professions and all levels of government) is only the beginning and in the Djirruwang Program's view an attempt of finding a suitable solution. Establishing stronger links with the mental health industry and working together through these issues will assist the process. There is an urgent need to address the issues identified in this paper and this work can only be performed by the willingness of the mental health industry and professional organisations. Failure to do so has the potential to perpetuate the current poor mental health status of Aboriginal and Torres Strait Islander people and therefore the potential to make significant structural, service and Aboriginal community based improvements will be lost.

Professionals, their organisations and management groups in the mental health field need to learn to work with Aboriginal people and not to continue to work on them. They are definitely not seeking permission on these issues – they are seeking support to enable them to move into 'adulthood' as qualified professionals within the systematic arrangements of the mental health industry. The question that management, services, professions and their educational systems need to ask themselves is, are they doing all they can to alleviate the emotional distress facing your Aboriginal colleagues and communities?

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