Supporting Aboriginal Mental Health Workers

Research into Perspectives on System Change

ARDS Aboriginal Corporation

2015

phn NORTHERN TERRITORY
An Australian Government Initiative

ARDS ABORIGINAL CORPORATION
CREATIVE MEDIA & COMMUNICATION SPECIALISTS

Acknowledgements

This research project was funded by Northern Territory Primary Health Network (NT PHN). Primary Health Networks are a Commonwealth Government initiative. NT PHN is responsible for commissioning and coordinating health services across the Northern Territory, including the positions of the Aboriginal Mental Health Workers and Partners In Recovery Facilitators who participated in this study.

The researchers wish to thank NT PHN for its generous support of the project and to acknowledge NT PHN's commitment to seeking-out and responding to the needs, priorities and perspectives of Indigenous peoples in the Northern Territory.

The researchers also wish to thank Miwatj Health Aboriginal Corporation, Laynhapuy Homelands Aboriginal Corporation and the Northern Territory Department of Health (Remote Health Centres) for their support and assistance throughout the course of the project.

The researchers wish to sincerely thank all the Aboriginal Mental Health Workers and Partners in Recovery Facilitators who so generously contributed their time and perspectives to this research. We hope this report will be of service to you, and to the individuals and communities with whom you work.

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Disclaimer

This research project received and was conducted in accordance with ethical approval from the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research. Reference Number: 2015-2424.

Aboriginal Resource and Development Services Aboriginal Corporation (ARDS) is a community development organisation that works with Indigenous peoples of northern Australia. ARDS' expertise is in cross-cultural communication and community education. While the research team strived to conduct this project with academic rigour, this report should not be considered an academic piece of work.

Northern Territory Primary Heath Network retains control over the publication and further distribution of this report.

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An Important Note

This report draws on Indigenous knowledges and ways of knowing, particularly in regard to the causation and treatment of illness and psychological disorder.

Galka is a Yolŋu Matha[1] (language) term relating to complex phenomena associated with spiritual, psychological and physical harm and healing within Indigenous communities and is a highly sensitive topic for many Indigenous people in the top-end of Australia. Non-Indigenous people should be respectful and take care in broaching these topics with Indigenous peoples. In particular, the term 'black magic' should be approached with caution, as it is an historical approximation of the Indigenous terminology used to described these phenomena and can be read by non-Indigenous people with various interpretations that may not be accurate from the local Indigenous worldview. In discussing *Galka* (or equivalents in other Indigenous languages) with Indigenous people, asking for permission, being transparent about one's interest in the topic and reading the non-verbal communication offered by the person you are talking to are all important points to consider.

The authors further wish to acknowledge that knowledge systems are fluid, dynamic and multi-layered. Care should be taken to avoid reductive or essentialising characterisations of a person or cultural group's knowledge. However, for the purposes of this report, a clear distinction between dominant-culture knowledge (Western-scientific) and Indigenous knowledges has been made in order to highlight the epistemological predicaments, conflicts and stress that Indigenous mental health workers report experiencing.

[1] Yolŋu Matha is a group of Indigenous languages spoken in North-east Arnhem Land. A significant percentage of the research participants were Yolŋu Matha speakers. For those participants outside of Arnhem Land, the term *Galka* was also at times used to describe these phenomena, as was the English alternative 'black magic'. Other language terms within the study region would also apply.

Terminology

Several choices around terminology have been made either to ensure consistency within the Report, to contribute to maintaining the confidentiality of the research participants and/or to ensure that this report remains accessible to the people who participated in the study.

Yolŋu Matha speakers regularly use the term 'Balanda' to refer to not only non-Indigenous people but also to the dominant-cultural worldview, in this case, involving Western-scientific models of mental health care. For that reason, when referring to the dominant-cultural, or Western-scientific, knowledges associated with mental health care delivery, the term 'Balanda' will be used.

Aboriginal Mental Health Workers (AMHW) and Partners In Recovery (PIR) Facilitators will be referred to as 'Indigenous mental health workers', or 'workers', except where a clear delineation of their titles is necessary. Despite important differences in their roles and skills, it was felt necessary to group the research participants under one term in order to maintain their confidentiality, given the small participant pool, uniqueness of research locations and sensitivity of the content discussed.

The people AMHWs and PIR Facilitators support will be referred to as 'clients', rather than 'consumers', 'service users' or 'patients', as 'client' is the term commonly used by research participants.

Executive Summary

A skilled and well-supported mental health workforce is a key factor in achieving positive, equitable outcomes for Indigenous consumers of mental health services in northern Australia.

While this report highlights and prioritises the perspectives and experiences of Indigenous mental health workers, it reflects a belief that is axiomatic amongst these workers – that Indigenous and non-Indigenous mental health professionals have a shared role to play in securing better mental health outcomes for Indigenous people in northern Australia. Within this, is an acknowledgement that Indigenous and non-Indigenous knowledges, beliefs and worldviews are valuable and have much to offer to an individual's capacity for wellbeing and recovery from illness.

In recent decades, the Australian health sector has embarked upon a paradigm shift towards the practice philosophy of person-centred-care. While still in its relative infancy, this shift increasingly affirms the dignity of people who access health services, providing higher standards of care in the process.

In parallel, within the health sector there is a growing recognition of Indigenous knowledges, cultural values, social structures and spiritualities as being unique and valuable. Perhaps more so, there is an acknowledgement that these dimensions of a person's worldview need to be validated and embraced in order for a health service system to provide equitable and effective health care.

This is part of the macro-context in which this research and its recommendations is located.

The roles of Indigenous mental health workers are wide-ranging in their scope and highly complex in their practice. Indigenous mental health workers demonstrate an extraordinary array of skills, and their contribution to a holistic approach to mental health care, which is adaptive to the complex socio-cultural contexts of their clients, is remarkable.

Indigenous mental health workers are committed to working both-ways - that is, drawing on and interacting with Indigenous and Balanda knowledges, beliefs and worldviews – in order to deliver versatile, responsive and identity-affirming mental health services. But this commitment is also a challenge, one that is inherently complex and that requires a specific set of knowledge and skills that can take years to master.

These diverse epistemological spaces in which Indigenous mental health workers operate can contribute towards significant personal stress, and the dominant-culture services in which they work are often ill-equipped to support them in navigating these complexities.

In some cases, non-Indigenous colleagues, supervisors and service managers have considerable experience in remote health service delivery, and a sound understanding of the cultural norms and values within their community of practice. However, this is not consistent across all sites, which remains of concern to Indigenous mental health workers who look to non-Indigenous colleagues for collaboration around dual assessments and support for Balanda worldview contributions to a both-ways approach to patient care.

Furthermore, the degree of understanding and skill of supervisors in being able to provide debriefing and support for Indigenous mental health workers is highly variable. Supervisory understanding of the unique tensions faced by Indigenous workers in negotiating their personal lives - that is, being a

member of their local Indigenous community, its cultural norms, worldview and socio-historical realities - and their professional lives - that is, being a member of a workforce largely structured around Balanda values - would be extremely valuable, especially during and after crisis situations.

A unique finding of this report is that increased access to peer-to-peer support and professional development opportunities would be of significant benefit in creating safe and supportive work environments for Indigenous mental health workers. This support could be provided both through teams large enough to encompass experienced and more junior Indigenous mental health workers, as well as through more formal opportunities to network with Indigenous mental health workers from other regions.

Forums in which Indigenous mental health workers can engage with their peers would also increase their collective capacity to reflect upon, define and develop their profession.

There are many practical challenges to structuring and delivering effective and equitable mental health services for Indigenous peoples in northern Australia, a good deal of which are recognised in the existing literature.

Some of these challenges are associated with the practical reality of delivering care remotely, including resource allocation and continuity-of-care disruptions. For Indigenous mental health workers, concerns around their workforce - including equitable access to professional development opportunities, staff numbers, leave opportunities, contract arrangements and access to essential infrastructure, such as consulting spaces and vehicles - add additional burdens to the issues of remote service delivery.

NT PHN is to be commended for commissioning this research. As Balanda psychological understandings and care delivery continues to undergo evolution, so too should Indigenous perspectives and models of practice. Learning from the perspectives of Indigenous mental health workers is an essential, and timely, step towards this development.

Central to the progress of a both-ways approach to service delivery, is a willingness to respect difference and to acknowledge the strengths and wholeness of others. These are qualities which Indigenous mental health workers are well-practiced in, and their expertise and perspectives can inform and contribute to the practice models practitioners utilise for all clients.

Recommendations Summary

Prescriptive recommendations for uniform change to discrete remote mental health services are best avoided. Instead, the recommendations, provided in more detail at the end of this Report, are a combination of broad principles and practical pathways, which services can realistically interact with, work towards and measure themselves against. Here, the broad level principles are outlined as a summary of the Recommendations that are made.

1. Professional Development

Indigenous mental health workers and their non-Indigenous colleagues should be engaged in an ongoing process of developing skills to recognise and interact with alternative knowledge systems, cultural values and worldviews.

2. Continuous Improvement of a Both-Ways Model of Best Practice

A both-ways model of mental health care should underpin all mental health services for Indigenous people in northern Australia. This model should be subject to ongoing enunciation, development and improvement, with experienced Indigenous mental health workers centrally involved in the process.

3. Service Structure and Workforce

3a. Adequate Staffing

Indigenous mental health workers are best supported and most effective when operating in teams with other Indigenous mental health workers. Services should be structured to ensure that Indigenous mental health workers do not work in isolation from one another.

3b. Workers Roles, Team Structure and Recognition

Indigenous mental health teams should be structured and resourced adequately to provide a broad spectrum of services to their communities, inclusive of community education and social and emotional wellbeing support. Services should continue to incorporate the perspectives of Indigenous mental health workers into how services are structured at a local level.

3c. Recruitment

A strategy for the recruitment of younger people into Indigenous mental health worker roles should be considered as a matter of priority in planning the future of remote Indigenous mental health services.

3d. Community Resources and Service Infrastructure

All Indigenous mental health services should have access to essential infrastructure and resources to perform their work safely and effectively.

3e. Service Coordination

Formal communication and handover practices between Indigenous mental health teams and non-Indigenous mental health service providers should be in place across the Northern Territory mental health sector. These practices should be based in a both-ways model of care and involve Indigenous mental health workers communicating with other services that their clients are accessing.

4. Community Education

Indigenous mental health teams should be sufficiently resourced to provide community mental health education in an ongoing capacity. Community mental health education should respect, validate and interact with Indigenous knowledges, languages and world-views, recognising these as strengths that can be complimented by non-Indigenous knowledge around mental health promotion and treatment.

Background and Context

The *Supporting Aboriginal Mental Health Workers: Research into Perspectives on System Change* research project was conducted by Aboriginal Resource and Development Services Aboriginal Corporation between August and December, 2015, with AMHWs and PIR Facilitators across three sites in northern Australia/Arnhem Land.

The AMHW Program was established in 2001 under the Top End Division of General Practice and has since evolved through various funding arrangements. Currently, the AMHW program sits under the Northern Territory Primary Health Network.

Partners In Recovery is a Commonwealth Department of Health national initiative which aims to improve service coordination and collaboration, for people with severe and persistent mental illness. It commenced in July 2013.

The last major evaluation of the AMHW program was conducted in 2004 by Gary Robinson and Amanda Harris of the *School for Social and Policy Research Institute of Advanced Studies*, Charles Darwin University. Their evaluation re-examined issues identified in a 2002 baseline report on the AMHW programme. The evaluators sought to ensure that the perspectives of all stakeholders were represented in its findings and consulted widely with a multitude of stakeholders including mental health clients, policy makers, general practitioners and community organisations. The evaluation used mixed methodologies, including identification of health centre processes, analysis of health service data from hospital and other databases, patient file audits and qualitative interviews with stakeholders. The evaluation's broad focus paid close attention to the processes, service structures and partnership agreements that underpinned the AMHW program as a whole. It also examined specific factors that impacted on the supports available to AMHWs.

The *Supporting Aboriginal Mental Health Workers* research project was far more focussed in its aims. While consultation occurred with multiple stakeholders, including clinic managers and non-Indigenous mental health nurses, this report seeks to highlight the perspectives and experiences of Indigenous peoples employed in AMHW and PIR Facilitator roles within particular locales, namely remote communities in northern Australia.

This selective representation of views is intentional. It seeks to prioritise and highlight the perspectives of Indigenous peoples who work at the coal-face of Indigenous mental health care, whose views have, historically, been sidelined from discussions and planning of remote mental health services in northern Australia.

However, Indigenous mental health workers do not work in a vacuum and the perspectives of Indigenous clients of mental health services, their families, carers and communities, as well as non-Indigenous mental health professionals and policy makers are all valuable, relevant and important to hear in any discussion around improving Indigenous mental health services.

As such, this report should be considered to provide a selective, rather than definitive, perspective of remote Indigenous mental health services and therefore, a qualified account of suggestions for it to change.

Methodology

The discussion below on the research methodology and analysis process are detailed due to the importance of being explicit about how research and communication in cross-cultural, multi-lingual spaces is conducted and also to contextualise the Findings, Discussion, and Recommendations outlined later in the report.

Research Participation

The following Mental Health service providers were invited to participate in the research: Miwatj Health Aboriginal Corporation, Laynhapuy Homelands Aboriginal Corporation and Northern Territory Department of Health (Remote Health Centres); at any of these locations: Galiwin'ku (Elcho Island), Yirrkala, Nhulunbuy, Laynhapuy Homelands, Angurugu (Groote Eylandt) and Nauiyu (Daly River). All services accepted the invitation and the researchers extended invitations to individual AMHWs and PIR Facilitators to participate, emphasising that participation was voluntary. Some of the workers declined or were unavailable during the research period while one service provider was not currently employing either an AMHW or PIR facilitator at the data collection stage.

A total of six Indigenous mental health workers participated in the study from three sites across northern Australia.

Research Question and Methodology

The study focused on the broad research question:

> *What perspectives do AMHW's and PIR Facilitators have around areas of need and opportunities for system change within remote Indigenous mental health services?*

The research question took particular focus on workers' perspectives relating to a) their own support needs and b) improving Indigenous mental health services.

In keeping with Harris and Robinson's 2004 evaluation of the Top End Division of General Practice Aboriginal Mental Health Worker Program, a qualitative Participatory Rural Appraisal (PRA) research methodology was utilised in this study in conjunction with elements of ARDS' well-established cross-cultural education methodology (also known as 'discovery education').

PRA is a research approach that involves the researcher positioning herself as a non-expert learner who engages with research participants in a participatory interaction, in this case, semi-structured interviews. The PRA methodology places high value on social development and on respecting the knowledge, values and beliefs of research participants. It seeks to understand human experience as it is lived and felt.

ARDS' community education methodology involves working with people from within the context of their own values, knowledge system and language. The approach seeks to identify and validate existing cultural knowledge around a given subject, and to use this knowledge as the basis for facilitating dialogues around other knowledges and worldviews. It is a two-way process of discovering insights into another person's worldview and knowledge system.

This methodology was utilised in preparing for research interviews, wherein Indigenous and non-Indigenous researchers worked together to breakdown dominant-cultural concepts within the research question, such as the concepts contained within the terms 'support', 'needs' and 'system change', as well as dominant-cultural knowledge around the construct of research itself. This process helped the researchers to contextualise the research project with participants and enhanced cross-cultural communication during interviews.

Research interviews were contextualised by first discussing the nature of the relationship between NT PHN and the services in which participants were employed. The researchers then explained the nature of the relationship between NT PHN and ARDS, including the reasons why NT PHN had funded ARDS to conduct the project and what NT PHN was hoping to acheive from it. This background story established why the researchers were asking questions of participants, a particularly important component to establishing trust around questions associated with sensitive topics, and ensuring participants were aware of what would happen with the information they shared, including how their identities would be suppressed in any publication of the research.

Semi-structured interviews then followed, involving a majority of exploratory, open-ended questions about participant's experperiences and perspectives on their work, their concerns, acheivements and hopes for the future. This PRA approach allowed for participants to lead the conversation through their own areas of experience, with opportunity for the researchers to ask questions around particular themes situated within the research question.

Interpreters were offered to participants whose first language was not English or Yolŋu Matha, as the researchers had facility in these languages. All participants declined the use of interpreters.

All interviews were digitally recorded and then transcribed before being offered back to the participants to confirm the transcripts accuracy. Some participants declined to review their transcript.

Data Analysis

Our approach to data analysis was determined by multiple factors, including the determinate sample pool, the qualitative nature of the data-set and the data-collection process itself. Importantly, NT PHN's need to respond practically and constructively to this report also informed how the data was analysed, interpreted and presented.

The researchers engaged in a reflective practice following each interview, reflecting on their own reactions during, and lasting impressions of, the interview, the strengths and weaknesses of communication during the interview and areas of confusion or misunderstanding that may have occurred.

A qualitative data analysis process was used to identify themes within the interview transcripts. Researchers conducted multiple sweeps through the data, identifying and coding individual themes, looking for patterns that emerged and finally reviewing the data as a whole to ensure the identified individual themes were true to the research participants' responses in context. The researchers also conducted a comparative analysis of the data, to gain further insights by exploring the differences in the data, across the research sites.

Ethical Considerations

Ethics approval was received from the *Human Research Ethics Committee* of the Northern Territory Department of Health and Menzies School of Health Research. Due to the relatively small sample pool, a number of safeguards have been put in place to protect the anonymity and privacy of research participants. These safeguards include de-identification of participant's names and specific roles, as well as their geographic locations and employers, in addition to the names of any clients, colleagues or other third parties, who may have been named in the course of an interview.

1.0 Research Findings

"It's big djäma[2], mental health. Seven days, 24 hours."

"I didn't want to do it for the money…I'm here to help my people, help them get a better life."

"I'm putting my heart into this work...for my community."

"I have to share my experience with other people."

- Indigenous Mental Health Workers

The roles of Indigenous mental health workers are wide-ranging in their scope and highly complex in their practice. The workers who participated in this study reported a diverse range of regular professional duties, including:

Conducting culturally informed assessments; interpreting during consultations between clients and non-Indigenous doctors and clinicians; providing relationship and anger management counselling; making referrals to non-Indigenous specialists and within local kinship structures; providing short-term Volatile Substance Abuse interventions; Drug and Alcohol (AOD) counselling; supporting people involved in the criminal justice system; providing post-release support for people exiting prison; conducting suicide interventions and counselling; doing therapeutic work with families; providing parenting support; facilitating community education around AOD issues and mental health literacy; supervising medications (monitoring and review); crisis response; formal and informal after-hours support work; trauma informed counselling; conducting and participating in research; supporting clients to access primary health care and social welfare services – such as Centrelink and Primary Health Services; social and emotional wellbeing work - such as organising bush trips, facilitating respite for consumers and carers; acting as drivers/escorts for community clinics; and organising community events.

Invariably, the workers involved in this study described their work as being holistic in nature and centred on a both-ways approach, which integrates dominant-culture knowledge and therapeutic approaches, with local cultural knowledge, social structures and worldviews, in order to prevent and manage psychological sickness and promote mental health. Workers commonly reported that particular duties tend to dominate their workload, at the expense of other priority areas – a theme that will be explored later. For some of the people involved in the study, their roles as a carers and support figures for people living with mental illness extends well outside the bounds of regular working hours, either through providing formal out-of-hours services, or through responding to need within their community, as required.

Many workers reflected on their motivations for engaging in mental health work which often stemmed from bearing witness to extreme psychological distress prevalent in their communities. For others, motivation came from an individual experience of mental illness and recovery. Across the board, it is evident that Indigenous mental health workers are driven by a passion to support the communities in which they work and live, and to improve the wellbeing of others; clients, carers, clans and communities alike.

[2] *Djäma* translates to 'work' or ' the conduct of business' in numerous Yolŋu languages.

Over the course of interviews with Indigenous mental health workers, numerous perspectives emerged around supportive factors that equip workers to perform their roles effectively and purposefully, while maintaining well-being in the process. Equally, numerous perspectives were offered on the challenges and barriers that are detrimental to the well-being of communities, and sources of concern for Indigenous mental health workers. Many of these perspectives are also linked, directly or indirectly, to the overall efficacy and sustainability of the local mental health services in question.

These perspectives, as they relate to the support needs of Indigenous Mental Health Workers, and to the challenges facing remote Indigenous mental health services, are outlined below.

1.1 Staffing

"We usually talk amongst ourselves to find a way… we look for the psychosis – can talk it over amongst ourselves – then we talk to doctors"

"I was just by myself…but it is my job, I've got to do it, I can't just walk out"

- Indigenous Mental Health Workers

Staffing within Indigenous mental health teams was a recurrent theme to emerge from interviews with workers. While there was no suggestion of establishing a standardised number of Indigenous mental health workers across locations, several perspectives around the benefits of working in teams with a critical mass of Indigenous mental health workers, came through strongly in the data.

Many workers observed that some day-to-day duties, such as supervising medication and providing transport for clients (including clients of other health services), are time-consuming to the extent that their team's capacity for mental health promotion activities such as community education, social and emotional wellbeing work and for mentoring less experienced staff, is severely limited. For some participants, these preventative and capacity-building activities were seen as priorities, while the lack of time and resources available to attend to them were a cause of frustration.

Numerous workers identified that the creation of additional Indigenous mental health worker positions (both clinical and community-based roles) would significantly improve the quality and breadth of mental health services they deliver, particularly in the areas of community education, mental health promotion, social and emotional wellbeing work and staff mentoring.

Some workers identified that working in smaller teams of Indigenous mental health workers (2-3) can be problematic when other team members are on leave. At these times, workers reported feeling exposed and alone, particularly when required to respond to crisis situations in their community. One worker shared a story of such an incident where, during a period when the only other Indigenous mental health worker at site was on leave, the remaining worker attempted to support a person who was highly distressed and in crisis. The crisis escalated and the distressed person produced a weapon, exhibiting aggressive and dangerous behaviour and putting the worker's physical safety at extreme risk. The worker narrowly avoided incurring a severe, potentially life-threatening injury and required stress-leave as a result of the event.

These workers explained that the creation of additional Indigenous mental health worker roles would help to address the issue of being left unsupported when other team members are on leave.

The workers also observed that having additional staff would increase their ability to take leave as-needed, rather than at the more limited times when other staff are available to cover their position.

Several workers noted that the dual assessment process – that is, ensuring that mental health assessments are situated in an individual's social, cultural, linguistic and normative behavioural context – is a critical function of Indigenous mental health worker roles. Workers observed that working in a team of peers (i.e. other Indigenous mental health workers) enhances the dual assessment process, and allows for dialogue with other local Indigenous people around how an individual presents, as observed through a local cultural lens. Workers also pointed to how larger Indigenous mental health teams strengthen the capacity to provide continuity-of-care to clients when workers are on leave, or are called upon to provide after-hours support. Finally, several workers reflected on the capacity of larger Indigenous mental health teams to satisfactorily respond to kinship and gender-based avoidance relationships, which are common within the social structures of Indigenous peoples. It was clear that the precise number of Indigenous mental health staff needed to achieve critical mass will vary from location to location, however it is necessary to ensure universal access to support from an *Indigenous* mental health worker in remote community settings.

1.2 Service Structure

"We tell them, "these are our clients, you can check them for general stuff [but]don't take our work. Mental Health is our business."

"[I need] time when I don't have to take over reception duties and when I don't have to sit and listen to other people having consults."

"I'm supposed to be dealing with patients out in the field, why should I suddenly be stuck with admin stuff?"

- Indigenous Mental Health Workers

The structure of the mental health services involved in this study varied significantly between locations. A central point of difference was the degree to which teams of Indigenous mental health workers operated autonomously and independently of the local community health clinic, to which most Indigenous mental health teams are still attached.

Workers within larger, more experienced Indigenous mental health teams expressed a strong sense of autonomy in how they define and prioritise their work. These workers also highlighted their agency in negotiating their relationships with non-Indigenous health professionals. Workers within these teams reported feeling confident to discuss their practice with their co-workers and supervisor, conveyed a clear understanding of the parameters of their role and regarded their work as purposeful and important.

In services with fewer Indigenous mental health workers, where workers were more closely integrated into the local community health clinic, workers were supervised by a clinic manager, who was generally responsible for overseeing the entire health service. Some of these workers reported feeling less control around prioritising their workloads, noting their frustration at having to perform tasks that they did not see as being a priority, or relevant to their role, such as taking on reception

duties for the clinic. One worker described the limited availability of their manager as a concerning issue.

One worker described the need for more specialisation within Indigenous mental health professions, saying that the expertise required for specific roles, such as clinical work, community education or counselling, is hard to acquire when a worker is drawn between a multitude of different tasks and activities. The worker suggested that a multi-disciplinary Indigenous mental health team, with diverse expertise within it, would be the best service model by which to advance Indigenous mental health professions and the quality of the services workers are able to provide.

1.3 Service Coordination, Service Gaps and Referral Pathways

"...ever since we got [name of community mental health service], they've sort of taken over seeing my clients.."

- Indigenous Mental Health Worker

Workers who were embedded in community clinics stated that they found contact and collaboration with other local community mental health services useful, however, such collaborations were not often formalised. One worker reported that another local community mental health service had taken on many of the clients the worker had been supporting, leaving the worker with only a small number of regular clients.

Workers were unanimous in their views on working with local police , and regarded police personnel as playing an important role in keeping them and their clients safe in crisis situations. Workers were confident in requesting support from police, as needed.

Several Indigenous mental health workers observed that the communication and handover process following inpatient admissions at Cowdy Ward (the psychiatric unit of Royal Darwin Hospital) and/or treatment from the Tamarind Centre in Darwin, is often directed towards non-Indigenous health professionals and focuses largely on medication. Workers explained that little attention is paid to any social, emotional or wellbeing support that the client may be engaged in at the time of admission, and that little information is shared in hand-over about a client's experience of the admission. Workers did not indicate whether these existing handover practices were concerning or problematic, however the topic of cross-service communication is one that will be explored in more depth in the Discussion.

Workers provided a mixed appraisal of the effectiveness of regional service coordination in supporting clients who travel between remote communities and regional centres. Many workers are diligent in monitoring and tracking their client's regular medications and Depot's (slow release injections), and prioritise communicating with clinics in neighbouring communities when they are aware a client has left the community or noticed that a client has missed a regular medication. However, some workers reflected that continuity-of-care for clients who travel is also dependent on health staff being aware of visitors entering the community who are receiving mental health treatment elsewhere. Workers stressed that when a client presents to a clinic outside of their home community, it is vital that clinic staff find out whether the person receives regular treatment elsewhere, and to then communicate with the person's treating team as soon as possible.

One worker shared an example of this communication not happening when their client presented at a neighbouring community clinic. The client was overdue for medication, which was not picked up by the neighbouring clinic, and resulted in the rapid deterioration of the client's mental health, which lead to a crisis situation where the client was eventually arrested by police.

Some workers identified that other services in communities, such as Community Development Programme (CDP - formerly *Remote Jobs in Community Program*) providers, are often open to sharing resources, such as community function rooms, but that this not often followed through or taken up. Other workers identified that collaborating with CDP and schools would be a valuable way to give CDP participants and students exposure to mental health work, work experience and a career pathway.

Most workers regarded the current availability of respite options for clients and carers as being adequate and easy to organise, while some workers identified that the total availability of out-of-community respite has diminished in recent years. Workers emphasised the value of out-of-community respite for clients, carers and other family members.

Workers also reported having good relationships with Alcohol and Other Drug (AOD) services, where they were available. Workers consistently described high levels of cannabis use as an ongoing issue for their respective communities and a frequent trigger for the relapse and onset of psychosis for their clients. Some workers commented that out-of-community rehabilitation services were the best option for clients dealing with AOD issues but that relapse was common because of permissive attitudes around cannabis use in communities. Workers were also of the common view that they require more training and expertise around AOD issues and more time for community education around AOD use and mental health.

Collaboration with local language centres was observed by one worker to be invaluable for the development of cross-cultural mental health resources and translating resources in other Indigenous languages into local languages.

1.4 Employment Contracts, Career Progression and Flexible Work Arrangements

One Indigenous mental health worker expressed concerns around not having a longer-term contract with their employer, saying that successive short term contracts (of between 6 and 12 months at a time) made it difficult to plan for the future or plan to take leave in advance. This left the worker feeling somewhat insecure about their employment. These concerns are particularly significant in light of several other workers' perspectives about the time it takes to develop the skills, knowledge and experience necessary to be a confident and effective Indigenous mental health worker, and to be accepted as such by the community. Several workers explained that this process can take years.

Some workers mentioned that flexible work arrangements, such as working part-time, would be desirable now, or in the future, as they approach retirement. This point is particularly pertinent given the average age of workers involved in this study is over 55. This point also has important implications in considering the size of mental health teams and for the recruitment of new Indigenous mental health workers, a theme that will be explored later.

A minority of workers also identified feeling that opportunities for career progression beyond their current role were limited which could be a source of frustration.

1.5 Infrastructure and Practice Resources

Several workers expressed concerns around inadequate access to infrastructure and resources, which compromised the quality of support and care they were able to provide to their clients and communities.

One worker cited the lack of a designated counselling space as a major concern. This worker shared a story about an instance of providing informal counselling to a client in the staff kitchen of the local clinic – the most private room the worker had access to. The client was seeking support around family violence they were experiencing when the perpetrator of the violence entered the kitchen, disrupting the conversation. This was a significant breach of the client's privacy and safety.

Workers also reported having limited access to work vehicles and/or of only having access to small cars that are not equipped for bush trips. Workers explained that these restrictions limited their capacity to do social and emotional wellbeing work and other therapeutic supports outside of the town/community setting.

Several workers suggested that a wellbeing or drop-in centre in their community would be of benefit to clients who did not have consistent access to meaningful daily activities or who had impermanent housing. One worker explained that this would also relieve them of having to open up their own homes to clients in need.

Some workers pointed out that there is often dormant infrastructure within communities, which could be utilised to provide additional office spaces for workers and wellbeing or drop-in centres for clients.

Numerous workers remarked that educational videos around mental health concepts are valuable for their own learning, and also useful in their work with clients, carers and for doing community education. Workers shared the view that audio-visual resources need to be produced in local languages in order to be effective.

Most workers reported that paper-based resources, such as flip charts, are rarely useful in client work, but can be helpful for workers in their professional development and learning.

1.6 Supervision and Working with Non-Indigenous People

"I've been trying to get to her for the past couple of weeks, about different things. In the end, if it's going to keep going on like this… I'm just wondering what I'm doing here"

"You can't go one day, two days and change the world, you have to stay three to four years, then you can see the environment."

"We need support, we are just like them [people in the community]."

- Indigenous mental health workers

The expertise of non-Indigenous mental health professionals, including psychologists, psychiatrists, mental health nurses and general practitioners, is highly valued by Indigenous mental health workers. However, many workers observed that the efficacy of these professionals is closely related to the length of time an individual has worked in a particular location and the degree to which they have an understanding of local languages, customs, culture and worldview. Additionally, the level of

understanding and appreciation the person has for the roles of Indigenous mental health workers was also considered an important factor in a non-Indigenous mental health professional's efficacy.

Workers' perspectives on management and supervision suggest that the availability of a manager/supervisor to discuss casework, provide guidance and support workers to consolidate knowledge and skills, particularly through following-up with training and professional development, is critical to a worker's sense of adequacy, security and purpose in their role. It is also an important factor in workers developing their professional practice and retaining skills and knowledge gained from training opportunities.

Another complex factor concerning management support for workers involves the degree to which a manager understands and/or can respond to the complex stressors Indigenous mental health workers often experience in their work. This factor is closely tied to a worker's capacity to self-care effectively and to cope with complex social and cross-cultural stress. This factor is explored in more depth in the sections below.

One worker pointed out that Indigenous mental health workers are members of the kinship systems, clans, and of geographic communities whom they support, and so experience many of the same challenges and stresses faced by their broader communities. Because of workers standing as competent professionals, this obvious fact is one that can be overlooked by non-Indigenous managers.

1.7 Working between Two Worlds

"When a person gets very sick we are involved in the middle of that problem with the family, you know, trying to get the message across, this gets us very stressed."

"People need to be out there, connecting with the old spirits – to the land, feeling good about it and after, coming back it feels great, but I wish I could do more of that."

- Indigenous Mental Health Workers

Indigenous mental health workers largely shared the view that their roles involve a both-ways approach to mental health care. This approach involves drawing upon and interacting with both Balanda and Indigenous knowledge and belief systems and diverse conceptualisations of phenomenon such as illness, causation, treatment and wellness.

Many workers spoke about the centrality of kinship to their work, and the self-evident connection between individual wellbeing and the maintenance of strong kinship ties. Workers emphasised the importance of their role in referring clients to appropriate kin-relations, in order to receive instruction, guidance and support around particular issues in their lives. Similarly, workers expressed deep regard for the importance of being on Country[3] and their role in promoting and facilitating clients, carers and families' access to Country in order to strengthen social and emotional wellbeing and also provide respite.

[3] The term 'Country' is commonly used to refer to the traditional lands associated with a particular family group or clan. It can also be used to reference being in non-town/community areas including homelands/outstations or 'out bush' where hunting and other traditional activities can occur.

There was also consensus amongst workers about the value of Balanda knowledge, approaches to wellbeing and the treatment of psychological disorders. A recurrent perspective highlighted the importance of training in Balanda classificatory and explanatory models of behavioural and psychological disorder. In the words of one worker:

> "*You have to start from Balanda documents, you have to get 'agitate', 'aggression, 'psychosis'"*

It is clear that Indigenous mental health workers value, embrace and actively integrate a both-ways approach into their practices. However, a significant stress for Indigenous mental health workers can occur when, in the course of their practice, Balanda and Indigenous knowledge systems and world-views come into conflict with one and other, particularly when the conflict manifests in the worker's interactions with clients, carers and families.

1.8 Knowledge, Worldview and Stress

In discussing work-related stress, one Indigenous mental health worker shared a story which highlights the complexity involved in working in the middle of different knowledge systems and worldviews.

An abridged version of the worker's account is offered below:

> "*One time, I was working with this man, he was going off…I had two sets of family fighting over him and I was right in the middle of this mess and had the family saying things about me, swearing at me… that fella there, accusing me; 'you're working for this black magic man, the Galka mob!'*
>
> *I didn't want to listen to him, I just wanted to help him, ''Cos you got something making you sick'. I didn't want to give up on him, I wanted him to get better, no matter what they said, things about me… it really hurt me inside and I just stood there thinking 'What am I going to do, just walk out? Let him get himself killed?'*
>
> *(Later) they were still talking 'Oh she's doing the wrong thing' because that's that Galka thing. 'He's sick from Galka, black magic cultural issues coming in from there'…if I would've stayed on I would've been burnt out, me in myself, I would've got sick…I needed to take a week off because I felt in my guts cutting me through, all those words in my mind...everything said about me and it was stressful."*
>
> *- Indigenous Mental Health Worker*

In this example, the worker responded to a client who was in crisis and showing signs of severe psychological distress. The worker positioned themselves as a caring support figure, and was attempting to diffuse the crisis and lead the client into a safer psychological and physical state. The worker was drawing upon Balanda conceptualisations and knowledge around causation and treatment of mental illness, which informed their interpretation of the situation and the nature of the intervention they chose to make.

The worker's actions conflicted with the expectations of the client and the respective families involved, all of whom had interpreted the situation through the lens of local Indigenous knowledge and world-view. As such, the worker's response was deemed grossly inappropriate. From the

worldview standpoint of the distressed man, the worker's response suggested a degree of collusion with the causative agent of the man's distress, namely *Galka*. From the worldview standpoint of some of the family members involved in the incident, the worker's response was not so much a collusion with the causative agent of the man's distress, rather, they saw that the worker's intervention and treatment of the distressed man as being 'wrong', because the man's condition was caused by *Galka*.

The worker did not elaborate on the possible reasons behind why the families perceived the worker's response as 'wrong', suffice to say, the reasons were in some way linked to the perceived causation of the distress **-** *Galka*.

In the aftermath of this event, the worker's manager supported the worker to take a week of stress leave. The worker reported feeling positively about the manager and the level of support they received. However, not all workers reported having sufficient access to support from supervisors/managers around the particular stresses and challenges of dealing with worldview conflicts.

Here, it should be noted that the public accusation of undertaking or colluding with *Galka* can have a significant impact on Indigenous people, as well as major implications and consequences for an individual's family and clan. These implications will be explored in more detail in the discussion.

1.9 Kinship and Professionalism

"It's sort of like family for me… it's not only work, it's family too."

"Even on holidays people still know how to find me and who cares for them."

- Indigenous mental health workers

Indigenous mental health workers occupy multiple social roles within their families, clans, communities and workplaces. These roles are situated in both kinship and professional contexts. For some workers, defining, limiting and negotiating the boundaries of their professional roles can be an ongoing process, which plays out in their interactions with clients, families and communities and also with their colleagues and employers. It is also a deeply individual process, from which worker's reach unique conclusions around how to reconcile the professional within their lives.

The ways in which workers draw boundaries between their private and professional worlds varied greatly. For some workers, drawing a rigid distinction between professional and private domains was seen as an important part of self-care. For others, who would have preferred to draw such a distinction, this was not possible when faced with clients who lacked alternative avenues of care. For these workers, their values around supporting their community, particularly those with specific kinship relationships to the worker, meant they could not turn down a client who was in need of food and a shower, even though it was after hours and they were at their home.

When the expectations of clients, families and employers are in conflict, Indigenous mental health workers report experiencing significant pressure and stress. This can impact heavily on a worker's wellbeing and ability to self-care.

Several workers shared stories of being caught between conflicting expectations of their employers and other community members. One example involved the arrival of a new respite vehicle in a

community, which had been supplied by an organisation on the basis it would be used for the sole purpose of providing respite for the primary carers of a worker's clients. However, several people in the community insisted that the vehicle be made available to them, and to the clients in question, disagreeing that the resource should only be accessed by a select few. The disagreement around the proper use of the vehicle caused many arguments and much jealousy in the community. The worker went on to say that the incident caused so much trouble that they refused to accept the vehicle when it was next made available for respite use.

This story was told as part of a larger picture of stress and inter-personal tension that the worker reported experiencing, leavening them to conclude:

> *"The only way on with these people work-wise is if I go home, stay home, on my own, instead of going around and visiting like I used to."*

1.10 Professional Development and Peer-Support

"Training is important. It's how you find out where you are… You have to focus on the brain heavily, this one is generating the whole body so we have to look after this one."

"I need to build some kind of working relationship with them and be in constant contact I think… I can probably learn a lot from them on how to deal with people here."

"…like sharing ideas…we can help them if they don't know what's happening in our communities…we don't know what's happening in other communities, maybe they can help us."

- Indigenous Mental Health Workers

Workers commonly identified that drawing on Balanda mental health concepts and approaches was fundamental to their work. Many workers stressed the importance and value of education and training around neuro-physiology and the interactions of the brain, body and environment, for themselves as well as for their clients and communities. Workers frequently cited the prevalence of cannabis use in their communities and the associated risk-factors for mental illness and/or relapse as a concern. Several workers identified further training around the interaction of drug and alcohol use and the brain as a priority area for their professional development.

Some workers explained that training and education around mental health is more accessible when it is delivered by Indigenous people and in a combination of English and their own first language. Some workers also talked about applied training, that is closely linked to their everyday practice, as being an effective and engaging educational method.

Peer-based support and professional development was a recurrent theme in interviews with Indigenous mental health workers. One of the strongest findings to emerge from the study is around the value and benefits Indigenous mental health workers derive from sharing their skills, knowledge and experiences with one another.

Workers widely acknowledged the cultural and linguistic diversity within their professional cohort and the uniqueness of the challenges that other Indigenous workers and communities face across Australia. Indeed, one worker explained these differences can present difficulties in communicating with other workers from different linguistic regions. Nonetheless, there was broad recognition that Indigenous mental health workers from across northern and western Australia share many

comparable experiences, stresses and challenges in their work, particularly around working between two worlds. Regardless of their differences, it is clear that many workers see other Indigenous mental health workers as unique peers, with whom they can share, learn and find support.

1.11 Sustaining and Expanding the Indigenous Mental Health Workforce

"There are big opportunities there for teaching the young people to do djäma, because we are getting too old now."

"I want to see young people come alongside me and my colleague looking at us how we work so they can (at) the same time do the training and see what we are doing."

- Indigenous Mental Health Workers

Many Indigenous mental health workers expressed concerns for the future of Indigenous mental health services in their communities. Workers observed that very few younger people in their communities appeared interested in pursuing careers in the mental health sector, noting that the few younger people currently training to become generalist health workers will not necessarily want to move into mental health work in the future. Workers were also concerned that the window of opportunity for younger mental health workers to learn from and be mentored by highly experienced workers is gradually closing, as many of these senior workers become close to retirement.

Workers offered various insights into barriers that prevent younger people entering the mental health workforce. Some workers observed that significant stigmas are commonly attached to people who display signs of psychological distress and illness in their communities. One worker remarked that mental health is an embarrassing term that can inhibit people from accessing or associating with mental health services. Another worker reported that stigma associated with the causation of psychological distress (as discussed in section 1.8) can also impact on people's willingness to associate with a person who is unwell, or be seen to be helping them

Workers identified various strategies that might help to address these stigmas and also help to open up career pathways for young people in the mental health sector. One worker stated that they avoid the use of the term mental health and try to reframe their work to focus on wellness and wellbeing, which have more positive connotations. Other worker's asserted that in order to address stigma around mental illness, greater attention should be given to community education and to promoting more positive attitudes towards people with mental illness and alternative frameworks for understanding psychological distress, its causation and treatment - a topic that will be covered in more detail in Section 1.12.

Another suggestion for change was around establishing partnerships with high schools and CDP providers, to create work experience opportunities within mental health services, where students and CDP participants could be guided by an experienced Indigenous mental health worker to gain new insights into mental health work.

To provide optimal support to people who have newly entered the mental workforce, workers identified that a person's training should largely be integrated into the workplace, where learning can be actively applied and accurately contextualised. Several highly experienced workers also

expressed their desire to mentor new workers, to support their learning and ensure that complex concepts can be explored in the new worker's first language.

1.12 Community Education

"Families don't care about people smoking gunja[4] until the person gets sick, then it's our problem."

"It's very hard to convince that person that he's got that sickness."

- Indigenous Mental Health Workers

Workers shared many perspectives on issues that impact on mental health and wellbeing in their communities. High rates of unemployment and cannabis use, inadequate housing, stress associated with living in large towns and the experience of traumatic events such as road accidents and natural disasters were some of the issues named.

Many of these issues are structural or environmental and beyond the remit of Indigenous mental health workers. However, several workers highlighted the need to expand community education programs around mental health. As discussed earlier, this would require an expansion of Indigenous mental health teams and/or the creation of multi-disciplinary Indigenous mental health teams wherein community education was one sub-specialisation, as several workers reported that while community mental health education is a priority area for them, they rarely have the time or resources to facilitate it.

Workers saw community education as an important step toward addressing stigma around mental illness, preventing onset of mental illness through reducing substance use and strengthening families' and communities' capacity to support people living with mental illness.

[4] Cannabis is commonly referred to as *gunja* in Arnhem Land.

2.0 Literature Review

A limited literature review was undertaken to contextualise the Findings of the research participant interviews. The review focussed on literature pertaining to Indigenous mental health workers in remote contexts and, where it provides insight into the lived experience of Indigenous mental health workers, literature associated with the broader generalist Indigenous health worker role.

Aboriginal Mental Health Workers (AMHWs) are integral to effective and equitable mental health care for Indigenous peoples in Australia, a point that is now widely recognised in the relevent literature (The Royal Australian and New Zealand College of Psychiatrists 2012, Australian Health Ministers, 2003). However, there remains a paucity of literature around the lived experiences of Indigenous mental health workers, particularly those who live and work in northern Australia.

Harris and Robinson's 2004 Final Evaluation Report of the AMHW Program focused on the efficacy and sustainability of remote mental health service processes and structures as they relate to the roles of AMHWs. The report showed that while many AMHWs made valuable contributions to remote mental health services, the implementation of the AMHW Program as a whole had not achieved its goal of developing mental health practices around the AMHW role.

The evaluation also looked at support structures for AMHWs at a local level, finding that two key factors determined the capacity of AMHWs to perform their roles effectively:

a. the availability of practitioners other than general practitioners (mental health nurses and/or health centre managers) who have been willing to invest time and effort in developing the AMHW's role in each health centre; and

b. the degree of support for a community mental health program by the local health care organisation.

The evaluation found that clinical and non-clinical practices in remote health services are often driven by reactive styles of response to acute care needs and that the associated pressures of this make it difficult to develop new systems of practice and organisation.

Harris and Robinson also point out that Indigenous mental health in the northern Australian context is not well understood and that its attendant cross-cultural complexity means there is "little in the way of an evidence base to support practice" (Harris and Robinson, 2004, p. 39).

Harris and Robinson asserted that, if and when the AMHW program is consolidated, evaluation efforts should be redirected to focus on the effectiveness of service delivery and client outcomes and that investment should be made in the development of preventative rather than reactive service strategies.

In their article "Decolonising Australian Psychology: *Discourses, Strategies, and Practice*" (2015), Pat Dudgeon and Roz Walker assert the need to decolonise dominant psychological theories and integrate "Indigenous cultural views and practices into mental health services, professional practice, and research" (p. 276). They also argue the necessity of fostering "the development and incorporation of Aboriginal standpoints and conceptual frameworks" into mental health practices, while ensuring the "implementation of cultural protocols and guidelines [are] embedded in reconciliation action plans of mental health services."

Dudgeon and Walker show that "*Ngangkaris*[5] recognise that much about their work may be unfathomable to non-Indigenous people and requires a leap of faith" (p. 290), but that non-Indigenous service providers are increasingly willing to take such a leap.[6]

Campion, Hunter and Skalicky (2007) conducted a series of workshops with generalist Indigenous Health Workers (IHW) in northern Queensland in order to explore some of the difficulties in recognising and treating mental health problems in local Indigenous communities. The workshops also provided a forum for IHWs to discuss the skills, attributes and approaches they thought would be important for community mental health educators to possess and implement. The consultations aim was to inform the creation of a community mental health education team consisting of one Indigenous and one non-Indigenous mental health educator.

The IHWs identified that knowledge and sensitivity to the local social and cultural context and an understanding of health issues and systems would be important attributes in a mental health educator. The workers also identified that a mental health educator "should be able to discuss issues such as black magic in a sensitive and constructive manner and to respectfully engage with traditional healers" (p.290).

IHWs reported that mental illness carries significant stigma and shame in many communities, which prevented some people from seeking help from IHWs, as did a fear of the potential consequences of seeking help around psychological distress, including: receiving forced treatment; being deemed an unfit parent or exposing an IHW to blame in the event that their condition deteriorated after treatment.

Fear of 'payback'[7], in the form of violence or 'black magic', was also identified as a reason why some people would not want to report on the psychological condition of a person from another clan. Clan differences were highlighted as being critically important for anyone facilitating community education around mental health.

Hudson (2012) provides an analysis of the disparity in high-quality training opportunities available to Aboriginal Health Workers (AHWs) in contrast to those available to non-Indigenous health workers with higher levels of English language literacy. Hudson argues that the increasing levels of expectation and responsibility placed on AHWs, to achieve health outcomes for some of the most intractable health problems in Australia, only exacerbate this disparity.

Hudson highlights imbalances in the structure of AHW roles, showing that workers are often "jack of all trades, master of none"' (Hudson 2012 p.vi) and that a restructuring of AHW roles is necessary to clearly delineate particularly specialisations between roles.

[5] *Ngangkaris* are traditional healers from the western desert region.

[6] This aspect of the literature points to a growing awareness within dominant-culture health services of the value of Indigenous knowledges, beliefs and cultural practice in achieving health outcomes. The authors are not suggesting that the roles of *Ngangkaris* and Indigenous mental health workers are similar or comparable.

[7] 'Payback' is an English approximation for processes associated with traditional Indigenous law which often include ceremonial determination of punishment for crimes committed (that is, crimes within Indigenous worldview, which may extend to phenomena such as *Galka*). In contemporary contexts, 'payback' can be undertaken outside of traditional processes, which can sometimes lead to the unauthorised use or threats of *Galka*.

In exploring the experiences of Aboriginal Health Workers (AHW), Mitchell and Hussey (2006) show how the expectations on AHW's to be 'all things to all people' are common and exhausting for these workers. The authors show how the burden of being seen as a 'carer' extends well beyond paid work hours for many AMHs, who are often sought out by community members who are in need of support, whether the worker is being paid for their time or not.

The Northern Territory Mental Health Service Strategic Plan 2015 – 2021, shows that planning for the sustainability of the mental health workforce is a key priority area for the Northern Territory Government and Department of Health. This includes a focus on succession planning and the recruitment and retention of Indigenous staff as well as the development of culturally appropriate services and programs for Indigenous peoples.

3.0 Discussion

There are many challenges to structuring and delivering effective and equitable mental health services for Indigenous peoples in northern Australia, a good deal of which are recognised in the existing literature. The literature also recognises various factors that contribute to effective workplace support for Indigenous mental health workers, some of which are highlighted and confirmed in the Findings of this report.

The perspectives presented in the Findings give voice to the lived experiences of Indigenous mental health workers, shining new light on the challenges, stresses and pressures that workers face in their day-to-day lives. These perspectives open up new possibilities for changes to remote mental health services which would support Indigenous mental health workers, improve remote mental health service delivery and be of benefit to Indigenous service users and communities. Some of these perspectives also raise questions that require further enquiry.

Three broad areas for discussion have been drawn from the Findings, which are outlined below. Each area explores the significance of various findings and the broader implications they have for the support needs of Indigenous mental health workers and for improving remote mental health services more generally.

3.1 Developing Awareness of Culture and Stress

Indigenous mental health workers often experience significant stress in working between different knowledge systems. When a conflict between knowledges plays out in a worker's interaction with other members of their community, as illustrated in section 1.8, this stress can be intensified.

For non-Indigenous mental health professionals, awareness of the complexity and gravity of this stress is essential if they are to collaborate with and provide meaningful support to Indigenous mental health workers. To highlight some of these complexities, it is instructive to look at how a non-Indigenous person might be impacted by an accusation of *Galka* or 'black magic', in contrast to the impact on an Indigenous mental health worker, as in the example from section 1.8**.**

Firstly, an accusation of *Galka* made against a non-Indigenous person is unlikely to have the same emotional impact that it would on person whose worldview is situated in the local cultural context. The non-Indigenous person's capacity to know and feel the significance of the accusation on a deep emotional and experiential level is far less than a local person's. Secondly, the non-Indigenous person's status as an outsider to the community is likely to diminish the strength of any kinship ties the person might have to an adoptive clan or family. This would diminish the adoptive clan's culpability for the person's actions. In any event, the non-Indigenous person is unlikely to have the same attachment and dependence on their adoptive clan as a local person who is born into it and whose very existence and place in the world is contingent upon it. Furthermore, the non-Indigenous person is free to leave the community and return to their own cultural group at any time, with little consequence for their sense of belonging to that cultural group. For the Indigenous person who shared this story, this is certainly not the case.

In this example, effective management support for the affected worker could happen at three key stages. Firstly, in providing backup support at the time of the conflict; secondly, providing the worker space to debrief and process the experience of conflict; and thirdly providing appropriate professional development opportunities for developing practices that would avoid or de-escalate such conflicts in the future. At each stage, the capacity to interact with Indigenous knowledges and beliefs, cultural protocols and social contexts is essential for effective management support.

For Indigenous mental health workers, interacting with multiple knowledges is an ongoing challenge that also occurs internally. Through their professional training, workers access dominant-culture knowledge around mental health, causation and disease.

Furthermore, the historical dominance of Balanda-centric approaches to health care in Australia has produced health service systems and professional cultures that do not always recognise, understand or respect Indigenous knowledges and cultural values.

Exposure to this professional context, alongside the introduction of new knowledge which may conflict with a worker's existing knowledge and worldview, can create a degree of internal conflict, particularly if a person's worldview subsequently shifts away from the normative position of their family and cultural group. The challenge of reconciling new and existing knowledges can thus also have implications for identity and one's sense of belonging to culture and community (as well as their service responses, as discussed below).

Again, to effectively support workers through such challenges, it is essential that a manager is aware of these epistemological dynamics, has a sound understanding of Indigenous knowledges and worldviews and is skilled in supporting workers to negotiate difference within the application of effective care responses.

3.2 Professional Development Both-Ways

The both-ways approach to mental health care, outlined by several workers, is indispensisble in the delivery of equitable and effective mental health services for Indigneous peoples in Australia, a point well recognised in the literature. Underpinning this recognition is a strong sense for the immense value that both Indigenous and Balanda knowledges have to offer Indigenous people who access mental health services.

A both-ways approach to mental health work draws on distinct knowledges and utilises them to support the wellbeing and healing of individuals and communities. Central to this is a respect for different ways of understanding the world. A both-ways approach acknowledges the wholeness of a person and respects their culture, knowledge, values and worldview as strengths. The approach draws on these strengths and embeds them in their responses to a person's support needs. A both-ways approach also makes available modalities for strengthening wellbeing that are situated in an alternative knowledge and value system. The approach then supports a person's choice to access and incorporate such modalities into their own lives.

There are many examples in the Findings that demonstrate the skills and insights Indigenous mental health workers have around using a both-ways approach. The role that workers play in facilitating their clients' access to diverse modalities of healing is remarkable.

The avenues to wellbeing that workers incorporate into their practice are many and range from referring clients to their appropriate kin relations for counselling and facilitating client's access to Country, through to interpreting consultations with non-Indigenous psychiatrists and providing psycho-education around the function of the brain and the neuro-chemistry of pharmacological therapies. The capacity of many workers to interact with different knowledges and modalities is considerable.

Nonetheless, the implementation of a both-ways approach is a difficult challenge and requires a high-degree of skill, self-awareness, flexibility and intentionality on the part of the worker. A successful both-ways approach not only requires the worker to hold in-depth understandings of both Indigenous and Balanda knowledges, but to be able to direct a sophisticated negotiation of worldviews between service, worker and client. The socio-historical context (as described in section 3.1) in which the approach is practiced is also critical to its success.

While many workers reported receiving training in Balanda concepts associated with disease and causation, there was little information shared which revealed training had been received about models of practice associated with mental health care, including neither Balanda models of practice, nor skills training in delivering a both-ways approach.

Both Indigenous and non-Indigenous mental health workers have an important role to play in the continual improvement of both-ways approaches to Indigenous mental health care. Critically, Indigenous workers should be heavily involved in the development of practice models in which these approaches are refined and clearly enunciated. This is an important step in enabling Indigenous mental health workers to have confidence in their capacity to work between two worlds, to constructively engage with the knowledge systems in each and to apply them to patient-centred care.

It is also vital for non-Indigenous policy makers and mental health professionals to genuinely engage with both-ways approaches and to continue the process of developing mental health care services which authentically value the contribution that Indigenous knowledges provide to effective client care.

Additionally, forums in which Indigenous mental health workers can engage with their peers is essential to strengthening solidarity amongst this invaluable cohort. In doing so, their collective capacity to support one another is enhanced, as is their capacity to reflect upon, define and develop their profession.

3.3 The Structure of Indigenous Mental Health Services

The Report Findings show that the structure of mental health services continues to vary significantly between participating locations. It's also clear that several of the issues around service structure identified by Harris and Robinson in 2004, such as inconsistent management support, continue to persist, while other issues have also emerged.

A continuing issue, which was identified by Harris and Robinson, involves the reactive nature of many remote Indigenous health services. In this case, Indigenous mental health workers attributed their lack of capacity to deliver preventative and mental health promotion services, such as

community education, to inadequate staffing numbers and an overabundance of other duties, such as supervising medications and providing transport to health centre clients.

Structuring Indigenous mental health services around the roles of Aboriginal Mental Health Workers (AMHW) was a key aim in the initial role out of the AMHW programme in 2001. Robinson and Harris' 2004 evaluation of the AMHW programme showed that this had not been achieved across all programme sites. Additionally, their evaluation found that where successful mentoring and guidance had been provided to an AMHW, this was attributable to the particular skills, capacities and motivations of individual practitioners such as a Clinic Manager or Mental Health Nurse.

Findings from the current research reveal that the efficacy of managers/supervisors and non-Indigenous colleagues was seen to be related to the individual's length of experience and degree of understanding of Indigenous culture and this efficacy was deemed an important factor for both the degree of managerial support received and the overall quality of the service delivered to clients.

However, in distinction to the Robinson and Harris 2004 evaluation, the Findings in this report suggest that it is the presence of strong peer-based team environments which better enable Indigenous mental health workers to define and develop their own practices and to more confidently incorporate Indigenous knowledges into robust, both-ways models of care. These workers also appeared more confident to assert their own priorities in working with other health centre staff. These workers were also much less exposed when a colleague took leave, as there was sufficient staffing in the team to cover the worker in their absence.

Conversely, workers who operated in isolation from other Indigenous mental health workers struggled to clearly define their work or assert their own priorities in working with other health centre staff and were more liable to be relegated to duties such as staffing the clinic reception desk and providing cross-cultural advice to visiting non-mental health professionals.

The expansive list of regular duties, outlined by Indigenous mental health workers in section 3.0 of the Findings, speaks to the enormity of their roles and the diversity of skill-sets required by a single worker to be effective in each domain of practice. While the distinction between Aboriginal Mental Health Workers and Partners in Recovery Facilitators is an important one, in practice, the overlap of responsibilities across these roles and the breadth of duties within them, remains considerable.

It is noted in the literature that Aboriginal Health Workers (AHWs) are often consigned to be "jack of all trades" but "master of none" (Hudson, 2012 p. vi). Explanations for this include that the training available to AHWs does not match the highly diverse nature of their workload and also, that a disparity exists between how Indigenous and non-Indigenous roles are structured. In turn, this results in a lack of specialisation in particular domains of AHW expertise, leaving workers to contend with contradictory objectives within a single and incredibly broad role.

It is argued that both factors are linked to an absence of recognition amongst non-Indigenous workers and policy makers, of the complexity and diversity of skill-sets currently required of the AHW role. Hudson (2012) argues that splitting the AHW role into distinct specialisations of practice, and providing specialised training in each, is key to addressing this.

As highlighted in Section 3.2, Indigenous mental health workers are also starting to call for the further specialisation of roles within Indigenous mental health services.

A further workforce issue identified is that flexible yet secure employment conditions will likely be a critical factor in sustaining remote Indigenous mental health services into the future. The creation of more permanent part-time positions would provide greater flexibility and assist some workers in their ability to self-care, particularly as they approach retirement. More flexible employment conditions will also help to retain experienced Indigenous mental health workers, whilst opening up opportunities for trainee positions that receive close mentoring from more experienced workers.

Adequate resourcing of services to allow safe and effective practice is essential. It was of particular concern that workers reported a lack of facilities in which to conduct routine consultations or respond to crisis situations.

Suggestions came from some workers that a drop-in or wellbeing centre would be of benefit for facilitating greater community engagement with mental health education, improve worker's ability to provide care and follow up support with clients, and potentially provide in-community day respite opportunities. It is noted that in other contexts, primarily non-Indigenous settings, drop-in centres have been considered a stop-gap solution that do not foster social inclusion, can lead to further marginalisation and stigmatisation and that do not address deeper problems around adequate housing, carer support and community education. In the context of remote communities where the majority of residents are Indigenous people connected through kinship ties, the provision of a drop-in or wellbeing centre may not lead to poorer social inclusion as seen elsewhere, and may provide significant benefits associated with the Indigenous mental health worker role. Further consultant with local service providers and clients would need to be undertaken to determine the appropriateness of a wellbeing centre in any given location.

The inter-related issues identified within the Findings relating to service structure and workforce suggest that disparity between Indigenous and non-Indigenous mental health services is an ongoing issue that the sector must respond to.

4.0 Recommendations

These recommendations are informed by the perspectives, priorities and concerns outlined by Indigenous mental health workers, in conjunction with a comparative strengths analysis of the participating service sites.

Prescriptive recommendations for uniform change to remote mental health services are best avoided due to the uniqueness of each service context, including their respective stages of program consolidation, their access to resources and rates of staff turnover. Instead, these recommendations are a combination of broad principles and practical pathways, which services can realistically interact with, work towards and measure themselves against.

It is to be noted that as this research solely reported on the perspectives of Indigenous mental health workers; the implementation of many of the practical pathways will require input from other stakeholders, including clinic managers and non-Indigenous mental health practitioners. A number of the recommendations are directed more clearly toward stakeholders who set and implement policies by which individual services are bound.

4.1 Professional Development

Principle

Indigenous mental health workers and their non-Indigenous colleagues should be engaged in an ongoing process of developing skills to recognise and interact with alternative knowledge systems, cultural values and worldviews.

Rationale

Non-Indigenous staff are often ill-equipped to engage with, or lack experience in working in, Indigenous worldviews and understandings of causation, wellbeing, illness, and approaches to treatment of psychological disorder.

Non-Indigenous managers/supervisors are often ill-equipped or lack experience in supporting Indigenous mental health workers as they attempt to manage the complex cross-cultural stress of working between two worlds. This includes supporting workers as they manage the tensions between their personal lives - that is, being a member of their local Indigenous community, its cultural norms, worldview and socio-historical realities - and their professional lives - that is, being a member of a workforce largely structured around Balanda values.

Indigenous mental health workers perceive that they have limited access to professional development and training, including limited opportunities for continuous up-skilling in Balanda models of mental health care, or for applied learning within their daily practice.

Pathways

i. Non-Indigenous staff engage in training.

- Cultural awareness training is provided for all new staff, including locum staff.

- Ongoing and in-depth training in Indigenous worldview and knowledges as they relate to mental health is undertaken as a form of continuing professional development for client-facing staff, particularly those who engage in dual-assessment processes.

ii. Non-Indigenous managers/supervisors engage in training.

- Training focuses on culturally responsive approaches to supervision i.e. that increases understanding of the unique stressors faced by Indigenous mental health workers and provides opportunities for skills learning in culturally appropriate support and de-briefing, and cross-cultural staff management.

iii. Indigenous mental health workers are involved in training for non-Indigenous staff.

- Indigenous mental health workers should be involved in the development and delivery of training for non-Indigenous staff, however this needs to be reflected in position descriptions and enumeration, and also needs to be considered against staffing levels and workload.
- Informal, 'on-the-job' training by Indigenous workers for non-Indigenous workers, while beneficial, should not form the bulk of training undertaken by non-Indigenous staff, as the ability to effectively deliver cross-cultural training is a unique skill set that not all Indigenous mental health workers will be trained in themselves. Furthermore, it de-emphasises the importance of the knowledge and skill set required by non-Indigenous practitioners by removing it from formal professional development requirements.

iv. Indigenous mental health workers are provided equitable access to professional development opportunities.

- Ongoing access to training in Balanda knowledge, such as bio-psycho-social explanatory models of mental health and emerging approaches to mental health care, is built into conditions of employment.
- Follow-up support to process, consolidate and apply new knowledge in the workplace is tied to training and supported by managers/supervisors.
- More experienced Indigenous mental health workers formally mentor less-experienced workers and this is reflected in position descriptions.
- Peer-based collaborative professional development, networking and support activities are regularly provided which bring together Indigenous mental health workers from multiple sites and regions.

4.2 Continuous Improvement of a Both-Ways Model of Best Practice

Principle

A both-ways model of mental health care should underpin all mental health services for Indigenous people in northern Australia. This model should be subject to ongoing enunciation, development and improvement, with experienced Indigenous mental health workers centrally involved in the process.

Rationale

A both-ways approach requires not only an understanding of Balanda and Indigenous knowledges and approaches to treatment of psychological disorder, but also highly developed skills to effectively negotiate the, at times profound, worldview differences between services, worker and client. However, current training does not appear to adequately address this unique skill set and Indigenous mental health workers do not always feel supported in their attempts to navigate these complex domains. A more clearly enunciated both-ways model of practice, which is informed by Balanda models of practice as well as Indigenous epistemological approaches to healing, and which is accessible to both Indigenous and non-Indigenous mental health workers, would contribute to an improved model of a care and a more supported workforce.

Pathways

i. Highly experienced Indigenous and non-Indigenous mental health and other cross-cultural workers collaborate to further enunciate and develop the both-ways model of practice, potentially in collaboration with universities or other relevant bodies.

- Work to define and develop a both-ways approach which acknowledges and incorporates the dual assessment process.

ii. Indigenous and non-Indigenous staff are provided professional development opportunities in the skills required to undertake a both-ways approach.

4.3 Service Structure and Workforce

4.3.1 Adequate Staffing

Principle

Indigenous mental health workers are best supported and most effective when operating in teams with other Indigenous mental health workers. Services should be structured to ensure that Indigenous mental health workers do not work in isolation from one another.

Rationale

The degree to which workers felt secure, supported and competent in their work closely correlated to the number of Indigenous mental health workers employed at their site. Furthermore, the ability of Indigenous mental health workers to perform the extensive number of service delivery and client-facing activities their roles require was influenced by the degree to which peer-support was available and work conditions were secure.

Pathways

i. Each site that employs an Indigenous mental health worker is reviewed for the presence of a critical mass of workers within the team.

- Staffing levels should be sufficient that if one worker goes on leave, the remaining workers will still be able to access appropriate peer-support in the event of a crisis.
- Indigenous mental health workers should have access to permanent and flexible work arrangements including permanent part-time positions.

- Where service practicalities prevent the employment of a critical mass of Indigenous mental health workers, solutions that involve collaboration or amalgamation with other services with an Indigenous health workforce should be considered.

4.3.2 Workers Roles - Team Structure and Recognition

Principle

Indigenous mental health teams should be structured and resourced adequately to provide a broad spectrum of services to their communities, inclusive of community education and social and emotional wellbeing support. Services should continue to incorporate the perspectives of Indigenous mental health workers into how services are structured at a local level.

Rationale

Indigenous mental health workers occupy unique positions in brokering diverse knowledges, cultural values and worldviews. Their work is complex, difficult and invaluable and deserves to be recognised as such and resourced accordingly.

Indigenous mental health workers are expected to engage in an extensive number of diverse service delivery and client-facing activities. The heavy burden of reactive duties, such as monitoring medications, consumes workers' capacity to deliver preventative services.

Workers reported that duties outside of what they perceived to be within the scope of their role, such as clinic administration or reception duties, were at times required of them, reducing the available time for activities workers felt were a greater priority.

In considering this principle, remote Indigenous mental health services should also be conscious of the advances in mental health service structure in other Indigenous, urban and non-Indigenous mental health sectors, drawing on these as appropriate.

Pathways

i. Consideration is made as to the development of sub-specialisations within Indigenous mental health teams, with workers able to develop expertise around singular disciplines such as community education, clinical work or Alcohol and Other Drug work.

- Team structures and workload are reviewed to ensure adequate time and resourcing is available for preventative work in particular.

ii. Managers/supervisors are aware of the scope of Indigenous mental health worker roles employed in their service, value their role-specific contributions to the broader health team and ensure duties required of workers are reflective of this.

- Colleagues within the service are made aware of what is an appropriate request for assistance in duties potentially outside the workers role.
- This does not preclude services incorporating general clinic tasks as part of individual mental health worker position descriptions where appropriate.

4.3.3 Recruitment

Principle

A strategy for the recruitment of younger people into Indigenous mental health worker roles should be considered as a matter of priority in planning the future of remote Indigenous mental health services.

Rationale

The existing Indigenous mental health workforce is rapidly approaching retirement age. This cohort holds valuable knowledge and experience that will be lost without a strategy to addresses the barriers that young people face in entering the Indigenous mental health workforce.

Pathways

i. Position descriptions of current senior Indigenous mental health workers clearly articulate duties associated with mentoring junior staff, and services ensure that these duties are appropriately resourced and overall workload remains achievable.

ii. Opportunities are created for younger generalist Indigenous health workers to undertake work experience with experienced Indigenous mental health workers to encourage transition into this specialist position.

iii. Appropriate and easily accessible training is provided for young Indigenous people wishing to become mental health workers.

- Initial training for new workers should focus on Balanda knowledge around human physiology, with a gradual exposure/introduction to neuro-physiology and psychology.
- Training should also include the skills required to undertake a both-ways approach in mental health care.
- Initial training should be paired with mentoring by an experienced Indigenous mental health worker, to support the new worker's engagement and capacity to process Balanda knowledge and worldview, and in particular in their own first language.

iv. Consideration is made to the development of partnerships with schools, tertiary education providers and CDP providers for the purpose of creating work experience opportunities within mental health services, in order to give younger Indigenous people greater and supported exposure to mental health work.

- Current Indigenous mental health workers need to be supported and trained to undertake the role of supervision of work experience personnel.

v. Community education to address stigma around mental health work is critical to the issue of staff recruitment. See Recommendation 4.4.

4.3.4 Service Infrastructure and Resources

Principle

All Indigenous mental health services should have access to essential infrastructure and resources to perform their work safely and effectively.

Rationale

Findings show that some Indigenous mental health workers are providing client-care from within their homes, often outside 'office hours', due to a lack of alternative community resources, such as drop-in centres. Other workers reported a lack of safe and private counselling spaces to be a major breach of client safety and confidentiality.

Access to other resources, such as vehicles, was perceived to be a barrier to performing a number of duties, including social and emotional wellbeing work in particular.

Pathways

i. Development of a baseline of resources and infrastructure that remote Indigenous mental health services should have access to, including at minimum a safe, private and dedicated space in which to undertake client consultations.

- Site-by-site needs assessments against the baseline would reveal any significant gaps in access to infrastructure and resources.
- Coordination amongst Regional councils and other community organisations may reveal dormant infrastructure that can be used to meet the needs of local mental health services, such as drop-in centres and wellbeing program spaces.
- Considerations around the provision of a service vehicle need to include appropriate vehicle type for remote social and emotional wellbeing work and clear and appropriate rules regarding community use that is negotiated in conjunction with the local Indigenous mental health worker who can advise as to possible community tensions arising from any given arrangements.

4.3.5 Service Coordination

Principle

Formal communication and handover practices between Indigenous mental health teams and non-Indigenous mental health service providers should be in place across the Northern Territory mental health sector. These practices should be based in a both-ways model of care and involve Indigenous mental health workers communicating with other services that their clients are accessing.

Rationale

Strong communication and handover practices between mental health services is an essential aspect of maintaining continuity-of-care for clients of mental health services. However, gaps in communication occur, in particular between health clinics in geographically discrete remote communities, and between services based in Darwin and remote communities. In particular, the perspectives of the workers in this study were that communication between non-Indigenous health

services and Indigenous mental health workers is less formalised, or less routine, than communication provided to non-Indigenous clinical staff within remote health services.

Pathways

i. Handover practices between external service providers such as Cowdy Ward and the Tamarind Centre in Darwin and Indigenous mental health services are formalised, to ensure that continuity-of-care is maintained in both clinical and non-clinical aspects of client care.

ii. Review is undertaken of the communication channels between remote Indigenous mental health services and generalist remote health services to ensure continuity-of-care for clients who travel between communities.

iii. Close collaboration with adjunct service providers, including the police, Alcohol and Other Drug services, and carer and respite providers should continue and be strengthened where necessary.

4.4 Community Education

Principle

Indigenous mental health teams should be sufficiently resourced to provide community mental health education in an ongoing capacity. Community mental health education should respect, validate and interact with Indigenous knowledges, languages and world-views, recognising these as strengths that can be complimented by non-Indigenous knowledge around mental health promotion and treatment.

Rationale

Community education around mental health is an essential component of preventative mental health care. Workers saw community education as an important step toward addressing stigma around mental illness, preventing onset of mental illness through reducing substance use and strengthening families' and communities' capacity to support people living with mental illness. Reducing stigma, utilising a wellbeing and wellness approach and focussing on positive approaches to people with mental illness were also considered important components of increasing the likelihood that younger Indigenous people would want to work in mental health.

However, a consistent theme in the research Findings is that much more community education is needed. Furthermore, workers strongly reported that despite community education being a priority from their own perspective, the time required for other duties frequently prevented them from being able to undertake adequate community education.

Workers identified that the most effective methods of community education is that which is delivered in the local language and utilises audio-visual multi-media. Other means, such as direct client and family education during consultation with workers, was also deemed beneficial.

Pathways

i. Significantly greater investment is made in order to expand community-based mental health education within Indigenous communities.

- Community education should focus on wellbeing, wellness and positive attitudes towards people with mental illness.
- Community education should reflect a both-ways approach, representing both Balanda and Indigenous understandings of wellness, health and healing.
- Community education resources should be produced in local languages.
- Experienced Indigenous mental health workers should be involved in the development of educational resources or programs.
- Highly experienced educators, who are able to appropriately navigate sensitive issues such as *Galka,* or 'black magic', should be involved in the development of educational resources or programs.

ii. In line with Recommendation 4.3.2, when considering the development of sub-specialisations within Indigenous mental health teams, community education is ensured as an essential sub-specialist role.

iii. Further in line with Recommendation 4.3.2, workers position descriptions and execution of duties is reviewed to ensure that adequate time for community education within their scope of practice is enabled.

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