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The Djirruwang Program: Cultural Affirmation for Effective Mental Health

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OVERVIEW

This chapter outlines the growth and development of the *Djirruwang Aboriginal and Torres Strait Islander Mental Health Worker Education and Training Program* (The *Djirruwang Program)* in Australia. The chapter describes what can be achieved when individuals, organisations, health disciplines and Aboriginal communities work in close partnership and learn from each other. We emphasise the importance of recognising Aboriginal cultural experiences and knowledge within the mental health curriculum, and providing a culturally safe environment to facilitate effective outcomes. Importantly, it stakes a claim for Aboriginal Mental Health Workers (AMHWs) as equally significant as the professions and disciplines of psychiatry, psychology, social work, nursing and occupational therapy in addressing the social and emotional wellbeing and mental health needs of Aboriginal and Torres Strait Islander peoples.

BACKGROUND

The year 2013 will be the 20th successive year in the life of the *Djirruwang Program*. It is an achievement worthy of celebration and reflection and an opportunity to review and share what we have learnt. The landscape of mental health services, Aboriginal health and mental health has transformed markedly over the past 20 years.

Over the past years, much has changed—the emergence of an Aboriginal mental health workforce onto the national mental health landscape is now firmly on the agenda. Aboriginal and Torres Strait Islander mental health is now one of the four priority areas of the National Mental Health Commission's '*A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*'.

The burden of mental ill health and distress in Aboriginal communities is well known. The negative impacts on Aboriginal social and emotional wellbeing (SEWB) can be understood through the historical issues confronting Australia and the current health and social circumstances (see Chapter 1, Dudgeon and colleagues and Chapter 2, Parker and Milroy for further information). The *Djirruwang Program* adopted a mainstream understanding of clinical mental health care by design. The aim is to address the over-representation of Aboriginal people in the 'hard' end of mental health care. The need for a skilled Aboriginal workforce within the mental health care system is central to responding to the levels of depression, psychotic disorders and high numbers of suicides in communities. Insisting that mainstream clinical care is inappropriate further exacerbates the stress levels for MHWs and services, and is likely to result in increased complications for clients and their families or, at the extreme end, becomes a matter for coronial investigations.

Aboriginal people are not accessing mental health services at a rate equal to the levels of distress. Access for this population often occurs during various states of crisis, and representation within acute care is approximately three times what the population distribution suggests it should be across many health services whereas, for the same population, access into community based mental health care is significantly under-represented—see Chapter 2 (Parker and Milroy). Throughout this entire 20-year period there have been repeated calls for, and reports highlighting, the need to build an effective Aboriginal and Torres Strait Islander SEWB and mental health workforce.

IMPROVING ACCESS TO MAINSTREAM MENTAL HEALTH CARE

The first way to improve access to mainstream mental health care is to increase the Aboriginal mental health workforce. While Aboriginal people from communities are far more likely to understand the needs of local families, networks and relationships, they often lack opportunities to obtain the skills to understand the care arrangements and systems in which mental health care occurs. Combined with this, the lack of genuine service relationships and partnerships with Aboriginal communities contributes to poor mental health service provision for this population. The rhetoric and paternalistic approaches are often a barrier to effective relationships with Aboriginal people.[1]

The second way to improve access to services is to:

- employ local Aboriginal people; and
- provide training in mental health care.

By doing this, Aboriginal people are provided with the skills to deliver a more culturally, responsive, safe and accessible mental health service (MHS). The flow on effects to the remainder of the mental health workforce will then follow.[2]

The third way to improve access is the development of a more culturally responsive workplace within local MHSs. The relationship between the MHS and Aboriginal communities is critical for this to succeed. The MHS has a responsibility to be informed through effective local working relationships and partnerships at all levels. These relationships need to be respectful and based on equity and equality and promote cultural safety. If the emerging workforce is supported well, development grounded in culture, local community and an informed base of clinical mental health care will occur.[3] The recipe is relatively simple: build and support the Aboriginal workforce, strengthen the formal service relationships with Aboriginal Medical Services (AMSs) and everything else will fall into place.

OVERCOMING THE CHALLENGES

The need to nurture this emerging professional Aboriginal mental health workforce is still very real. The challenges still exist. These challenges were identified in two published papers almost 10 years ago claiming that Aboriginal professionals were treated as 'seasonal workers'[3] and the system needed to support this Aboriginal mental health workforce.[3, 4] Brideson argued for:

> *..the support of the mental health industry and professional organisations to move towards systematic adulthood with respect to 1) the professional recognition of students and graduates of the program, and 2) the need for professional organisations, and service management and staff to take responsibility in their responses to Aboriginal mental health issues.*[4(p1)]

These papers expressed concerns of the Aboriginal mental health workforce being undervalued by the professions and the services in which they work. Some of the early historical accounts

of developments of Aboriginal mental health worker education and training highlight both the need for recognition and the lack of support within the main stream.[5-11] Several papers have now been written about the establishment of the *Djirruwang Program*.[6,7,2] A systematic review of the literature in this area would add to the knowledge of what works, what has been learned and the role of cultural affirmation within this context.

Leaders of Aboriginal Mental Health Training in Australia

Despite little being written in this area, there have been many significant contributors to Aboriginal mental health training in Australia. Examples in the early to mid-1990s include:

- the *Marr Mooditj Program*, Western Australia (WA), developed by Dr Joan Winch;
- the Aboriginal Counsellors Course, Centre for Aboriginal Studies (CAS), Curtin University, WA, developed by Darren Garvey and Harry Pickett;
- the *Bachelor of Applied Science and Diploma in Aboriginal Community Health* at the CAS, Curtin University, WA, developed by Glenys Grogan; and
- the Cape York Aboriginal and Torres Strait Islander Mental Health Worker Program, developed by Dr Ernest Hunter in Queensland.

Throughout the 2000s there were a number of developments through the AMS networks, the NSW Aboriginal Health College—including the work undertaken by Trish Nagel through the Australian Integrated Mental Health Initiative (AIMhi) and many others. Key drivers and advocates for developing a critical mass of professional mental health workers in Australia include: Professors Pat Dudgeon, Beverly Raphael and Helen Milroy, Dr Tony Williams, Darren Garvey and many others. Early Aboriginal leaders and advocates for mental health training include Cyril Hennessey, Dr Robyn Shields and Pat Swan-Delaney.

THE DJIRRUWANG PROGRAM DEVELOPMENT AND DELIVERY

The *Djirruwang Program* emerged from the Koori Mental Health Outreach Workers Training Program which commenced in November 1993. The program was originally based in Queanbeyan, NSW. It was funded by the Commonwealth Department of Health Rural Health Support Education and Training (RHSET) Program. A number of Aboriginal and non-Aboriginal staff have worked in the program. Professional disciplines included Aboriginal mental health and drug and alcohol workers, psychiatrists, psychologists, social workers, academics, policy makers, sociologists and sexual assault counsellors. Input from Aboriginal Elders and Aboriginal leaders has been significant and central to program success.

The *Djirruwang Program* was a pioneer in the establishment of a clinical-based tertiary level mental health course in Australia designed for Aboriginal and Torres Strait Islander peoples. The program was the first course within Australia to incorporate the *National Practice Standards for the Mental Health Workforce* (The Practice Standards) within the course curriculum. The program was also the first course in Australia to embed the Aboriginal and Torres Strait Islander Mental Health First Aid Certificate within its curriculum structure.[8]

The *Djirruwang Program* has restricted entry, and is designed for Aboriginal and Torres Strait Islander peoples to gain high quality knowledge, skills and attitudes in the field of mental health. This is achieved by building on people's knowledge and combining mental health theory with clinical practice. The program maintains the opportunity for people to gain formal mental health qualifications at certificate, diploma and degree levels.[9]

Program Aims

The aims of the ***Djirruwang Program*** are to:

- Educate and train Aboriginal trainees to develop the appropriate knowledge, skills and attitudes to work as an Aboriginal Mental Health Worker (AMHW);
- Develop the skills needed to work effectively in a community mental health setting; and
- Develop skills to assist communities to identify mental health needs and initiate primary prevention and early intervention programs.[6]

Curriculum Content

The initial curriculum for the *Djirruwang Program* was developed by Kanowski and Morgan (mental health nurses) with input from an Aboriginal Education Committee. The curriculum was broadly based and included units on counselling, mental health assessment and treatment, drug and alcohol and sexual assault studies, Aboriginal history and culture, suicide prevention, assessment and intervention, and a range of related subjects. Clinical skills were developed during which Aboriginal trainees worked in close contact with non-Aboriginal clinicians. The trainees were required to meet a range of competencies in order to pass the course.

The initial intention was to provide trainees with a Health Service Certificate provided by the NSW South Eastern Health Region. In 1995, negotiations between Charles Sturt University (CSU), the Health Service and the Aboriginal Steering Committee resulted in upgrading the qualification to an associate diploma and later to a diploma and degree status. Students had the option to graduate with a certificate after one year, a diploma after two years and a degree after three years of academic study and on-the-job training.

In 2002, the curriculum and course structure were revised under the guidance of a National Reference Group. Significantly, the new curriculum was underpinned by the Practice Standards to ensure that *Djirruwang Program* graduates had the skills, knowledge, values and attitudes of like-minded health professionals, whilst maintaining a deep sense of cultural integrity.

The program developed a Clinical Handbook and Course Competencies document to assist students to gain meaningful, practical experience in the clinical environment. The Clinical Handbook is an important historical development that remains in the course structure of the program. The current Clinical Handbook is still underpinned by the Practice Standards, 2002. The *Djirruwang Program* has continued to ensure that the curricula aligns with the Practice Standards as well as incorporating best practice models from complementary health programs, such as community health and nursing. The program has continued with this approach to assert and encourage professional recognition and professional status in the mental health field.[10]

Ongoing Evaluation and Review

The program has continually been evaluated by the university with input from the mental health professional sector. Ongoing evaluations of the program have recorded the direction and continual build of evidence. Each evaluation has found the program to be unique, valuable and meeting the needs of health services by developing a well qualified Aboriginal mental health workforce.[6, 11]

The last external evaluation of the *Djirruwang Program* was undertaken in 2010. This review identified new opportunities to enhance the skills, knowledge and attributes of the students, with far reaching implications for the professionalism of graduates. The review highlighted key areas for engagement with industry partners, the university and the student cohort which

has led to informed curricula development and change. This has seen the development of new curricula in 2013, which include a greater emphasis on dual diagnosis, pharmacology and understanding of the diversity within the Australian demographics.[12] Whilst the establishment of new curricula is a positive move forward, the *Djirruwang Program* has, and maintains, a fluidity that embraces industry contributions and inclusion of current practices into the teaching within the program.

The program has undergone a number of changes since it first began in 1993. With the growing interest in the area of Aboriginal mental health, the program was offered as an undergraduate degree program—Bachelor of Health Science (Mental Health). The program continues to recognise the importance of having Aboriginal lecturers as an integral part of the success of the program.[13]

Course Delivery

The program was, from its inception, a 'block release' model of work-based training coupled with academic study. The degree course is conducted over a three-year period with two semesters each year. The course is delivered by a mixed mode—a combination of face-to-face residential schools and study within the home/community/work environment. This external component is supplemented by online teaching materials (modules) and compulsory workplace experience. Each semester, students undertake four subjects as a full-time equivalent student.[12] CSU have a number of support services for students that complement the delivery of the *Djirruwang Program*. These are provided through Ngungilanna Indigenous Student Support at the Wagga Wagga Campus.

Recognition for Excellence

The program has had significant impact across the mental health sector and has won and has been strongly associated with a number of Mental Health Services awards including:

1996	The MHS Award
2003	College of Psychiatrist Award – Tom Brideson
2005	In partnership with the former Far West Area Health Service won a NSW Health Aboriginal Health Award in workforce development
2005	In partnership with the former Far West Area Health Service won a Silver Award at the 2005 Premier's Awards
2008	Australian Learning and Teaching Council Award
2010	Premier's Award for Excellence, Greater Western Area Health Service

CURRENT PROGRAM

The program is currently headed by an Aboriginal Director, Faye McMillan. It is still actively supported by several program founders and early students of the original program. The program is now fully supported, staffed and funded by Charles Sturt University (CSU), Wagga Wagga NSW. The issue was always about generating sufficient student numbers for the program to become self-sustaining within tertiary and health service environments.

Through the *Djirruwang Program*, CSU has played an extremely important role as the preferred education provider for trainees in NSW Mental Health Services. This model of education and workplace training provided significant results for employment opportunities and service provision to members of the Aboriginal community in many Health Services of NSW.[14] The

Djirruwang Program has extended across five states with NSW and WA having equal numbers of students. WA has modelled significant parts of their development of Aboriginal mental health professionals on the NSW Health Service's trainee program.[15] Many of the graduates employed in mental health positions are providing care to Aboriginal people experiencing mental health problems.

Program Outcomes

Since the *Djirruwang Program* commenced there have been 137 graduates who have attained relevant mental health qualifications and are making positive contributions to the lives of individuals, families and communities in various ways. The program is now seeing two generations obtaining qualifications through the program. There are currently 105 students enrolled in the program which promotes collegial networks of like-minded people with mental health skills and qualifications.

Graduates of the program have gained employment in senior and influential roles in a number of areas. This reflects that the skills and knowledge gained from their qualifications are portable and transferable across a range of settings in Human Services (e.g. Social Work or Psychology and related disciplines). These program outcomes are likened to an 'Aboriginal mental health superannuation scheme' that contributes to longer term human capacity through investment into human resources within communities. The continued investment in such programs will reap sustainable long term benefits for communities, services and people.

WHAT ARE THE SUCCESS FACTORS?

Some significant developments that have contributed to the program's success include:

- Periodic external evaluations to improve and build the evidence base;
- Ongoing program review as an ongoing quality performance issue;
- Embedding the *National Practice Standards for the Mental Health Workforce, 2002;* and
- Achieving professional recognition of the qualification of the Bachelor of Health Science (Mental Health) by the Indigenous Allied Health Australia (IAHA) 2012.

The Role of Cultural Affirmation in Program Development and Delivery

The single point of difference between the development of the *Djirruwang Program* and the major mental health professions is that cultural affirmation is central to the design and embedded throughout the program. Cultural affirmation along with the development of skilled Aboriginal mental health professionals, in accord with the mental health profession's own practice standards, is central to the identity of the program. This is conducted in culturally respectful ways which sets this program apart from other disciplines as an emerging independent profession in its own right and within the matrix of multidisciplinary mental health care. Cultural affirmation:

- is the most important foundation of the program and the major contributor to its growth and development over 20 years;
- informs the structural arrangements, curriculum and implementation strategies that are meaningful to Aboriginal and Torres Strait Islander peoples.

Notions of cultural affirmation need to be implemented by those who want genuine change and show genuine leadership.

The Role of Partnerships for Effective Implementation

The *Djirruwang Program* would not be the success it is today without the establishment of effective partnerships between Aboriginal organisations, Elders and Aboriginal community leaders, local health services, academic bodies and student and family groups. The program is a positive example of people, organisations and cultures working together to achieve set goals. The partnerships were based on mutual respect and a both-ways learning model. Aboriginal people taught non-Aboriginal people about Aboriginal issues, culture and cultural respect and non-Aboriginal mental health staff provided education and training in western approaches to mental health and wellbeing treatment and care.

FUTURE DIRECTIONS

Since 2012, graduates and students from the Bachelor of Health Science (Mental Health) across the country have national representation through IAHA. This is a significant step in supporting the Aboriginal mental health workforce and the allied health workforce and Aboriginal Australians.[16] Essentially, for the first time Aboriginal and Torres Strait Islander mental health practitioners belong to a professional body that will advocate on their behalf, alongside other allied health professionals at the national level, for vital changes across the sector including a national awards structure.

There have been historical struggles to formalise these arrangements into a recognised professional association—it has been a long journey going back to the mid-1990s. This decision will ensure Aboriginal mental health remains high on the agenda. It is an opportunity for collective responses to issues affecting this workforce through active participation, choice and control of educational processes that are empowering to Aboriginal and Torres Strait Islander peoples. But most importantly it validates the belief, hard work and persistence of the many graduates of the *Djirruwang Program* into a valuable professional association.[16] The *Djirruwang Program* provides compounding benefits through longer term gains for graduates and workplaces across a range of human services and communities.

Challenging the Mental Health Disciplines

The emergence of programs such as *Djirruwang* creates challenges for the mental health system to recognise and acknowledge the qualifications and the role of Aboriginal mental health practitioners. The *Djirruwang Program* is about Aboriginal people determining and responding to a set of needs in culturally appropriate ways rather than the disciplines determining what we should be aspiring towards. If those of us seeking genuine transformation in Aboriginal mental health only ever focus on the five disciplines—Psychiatry, Psychology, Nursing, Occupational Therapy and Social Work—we risk overlooking the relevance and appropriateness of value of culture being incorporated as a key principle of mental health education and training. The failure (until recently) of these disciplines to acknowledge and affirm culture may help to explain why Aboriginal Australians are underrepresented in almost all health-related occupations, including psychology, and why Aboriginal students are underrepresented in graduate courses in health.[17, 18] Unless we challenge these disciplinary fortresses, we risk supporting the power imbalance that still exists within services, professions and disciplines that diminishes the real potential and value that an Aboriginal mental health workforce brings.

Positive Examples of Structural and Curriculum Reform

However, there is movement across the mental health professions. For example, the Australian Psychological Society (APS) has recently developed a Reconciliation Action Plan and the Australian Association of Social Work has a position statement relating to Aboriginal people. There is a substantial increase in Aboriginal enrolments in courses in medicine due to a process

of cultural affirmation in the formal structural and curriculum arrangements supported by the Australian Indigenous Doctors' Association (AIDA) and the Australian Medical Association (AMA). For the last two years, Aboriginal student enrolments have reached 2.5 per cent of the student population (compared with 0.8 per cent in 2004); in doing so, they have broken the barrier in terms of Aboriginal student numbers. This outcome provides both a formula and further challenge for all other disciplines in mental health care to improve Aboriginal student numbers in a supported structure. Some of these challenges and solutions are outlined in the *National Medical Education Review: 2012*,[19] which emphasises that:

> *To achieve this requires sustained and accelerated support from governments, education and health sectors to increase the recruitment, retention and completion rates of students, as well as work environments that encourage medical graduates to practice and specialise in their chosen field.*[20]

> *The implementation of the curriculum framework has not only resulted in the development of more relevant Indigenous health content, but has also stimulated a number of highly effective and more culturally appropriate pedagogical approaches in some schools.*[21(p1)]

The approach by AIDA focuses on real and sustainable structural reform to the entire base of medical training with the support from Deans of Medical Faculties and the AMA.

Embedding Culture in the Curriculum

There is also some interesting work emerging from the Vocational and Education and Training (VET) sector that highlights the value of embedding culture and affirming processes:

> *Where it is viable for curricula and models of delivery of education and training to incorporate elements that affirm and accommodate Aboriginal people's culture, it follows that such practices are also likely to realise improved outcomes for Aboriginal Australians.*[22(p8)]

> *If a strong sense of continuity of self-identity safeguards young people against taking their own lives, it may also have positive impacts in other domains in which people 'invest' in their futures, such as education, health, a career and relationships with family and community.*[22(p10)]

> *To promote a positive sense of cultural identity for Aboriginal students in education settings requires respect for and affirmation of Aboriginal students' culture. Coupled with evidence that a positive sense of identity is important for wellbeing more generally, the case can be made that material and activities to support this should be incorporated into curricula wherever possible.*[22(p43)]

CONCLUSION

This chapter has tracked the 20 years of history of the *Djirruwang Program*. The contribution to the mental health and wellbeing workforce through the Bachelor of Health Science (Mental Health) is impressive and far beyond its humble beginnings of five trainees in a pilot program at Queanbeyan, NSW in 1993. It has highlighted that their commitment to making meaningful improvements to the lives of Aboriginal Australians experiencing mental health issues is evident. The flow-on effects of supported education and training of students demonstrates that programs that positively validate and affirm cultural difference are both critical and central to their success. The *Djirruwang Program* can be proud of its foundations and its ongoing contribution beyond the mental health area. The program values Aboriginal people's experiences, and affirms all aspects of culture within the curriculum, structural arrangements and implementation. It is a story that is broadly based into the sphere of human services professions and one that values Aboriginal people at the core of all developments. This is the success story that is worthy of celebration and cultural affirmation in action.

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