

NEW SOUTH WALES ABORIGINAL MENTAL
HEALTH WORKER TRAINING PROGRAM:

Implementation Review

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Implementation Review

Carol Watson and Nea Harrison | January 2009

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FOREWORD

The high rate of mental health and social and emotional wellbeing problems in Aboriginal¹ communities is acknowledged by governments across Australia. Targeted programs to address these issues are being further developed. More extensive research with, and by, Aboriginal communities on the best way forward is starting to take place.

Under the *NSW Aboriginal Mental Health and Well Being Policy 2006–2010*, a key strategy to drive reform is the New South Wales Aboriginal Mental Health Worker Training Program.

This Program employs a unique approach to enhance the Aboriginal mental health workforce in New South Wales (NSW). It is underpinned by the principle of ‘growing your own workforce’. Trainees are recruited from local communities to work in local communities. They are supported through a structured on-the-job supervision and training program as well as tertiary-based learning. Aboriginal Mental Health Worker Trainees are permanent, full-time employees of NSW Health.

Funded by the NSW Government in 2006, the Program is being implemented across all NSW Area Mental Health Services and from 2008–09 is moving from Phase One of the program, 10 positions across five areas, to Phase Two of the program, an additional nine positions. This will bring to more than 70 the number of Aboriginal Mental Health Workers in NSW—as well as more than 15 in Aboriginal Community Controlled Health Services (ACCHSs)—that are funded by the NSW Government.

The Traineeship Program is part of the wider NSW Aboriginal Mental Health Workforce Program, which is enhancing positions in ACCHSs and developing a Clinical Leaders Program for Aboriginal Mental Health in all areas.

The *Implementation Review* report indicates that momentum is building around the Program and that it is generating significant interest far beyond the original intention and far beyond the borders of NSW. While the full impact of the Program will only be demonstrated in years to come, it is already showing that it can build and sustain a workforce through the approach of coordinating work and study for the Trainees within a system of peer support, supervision and mentoring.²

One of the significant elements for success of the Program for Trainees has been strong direction and leadership from the NSW Government and the NSW Department of Health, and thence from Area Health Service Chief Executives and Directors of Mental Health through to Team Leaders, who are responsible for the day-to-day activities.

¹In this report, the term ‘Aboriginal’ is inclusive of Torres Strait Islander people.

²Brideson, T and Jones, C (2008) The NSW Aboriginal Mental Health Workforce Program, *Auseinet Newsletter*, Issue 29, November 2007, pp. 20–2. Available at: <http://www.auseinet.com/resources/auseinet/netter29/auseinetter_29.pdf>.

With Phase Two of the Program coming into operation all Area Health Services, including Justice Health, are now involved and either supporting or recruiting Trainees.

The enthusiasm and commitment of Area Health Services to implement this Program is to be commended, as is the work over many years by Aboriginal people, senior academics and staff from tertiary institutions, funding bodies and mental health services to bring this Program to fruition.



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ABBREVIATIONS

ACCHS	Aboriginal Community Controlled Health Service
AHS	Area Health Service
AMHWTP	Aboriginal Mental Health Worker Training Program
AMS	Aboriginal Medical Service
CDEP	Community Development Employment Project
CRCAH	Cooperative Research Centre for Aboriginal Health
CSU	Charles Sturt University
DoCS	NSW Department of Community Services
FWAHS	(the former) Far West Area Health Service
GSAHS	Greater Southern Area Health Service
GWAHS	Greater Western Area Health Service
HECS	Higher Education Contribution Scheme
HNEAHS	Hunter New England Area Health Service
MHDAO	Mental Health and Drug & Alcohol Office
NCAHS	North Coast Area Health Service
NETPO	(Mental Health) Network Education and Training Project Officer
NSCCAHS	Northern Sydney Central Coast Area Health Service
NSW	New South Wales
OATSIH	Office for Aboriginal and Torres Strait Islander Health
TAFE	Tertiary and Further Education

PREFACE

The Reviewers undertook to document and evaluate the first year of the State-wide implementation of the NSW Aboriginal Mental Health Worker Training Program (AMHWTP) and to draw out sound practices that could guide the future implementation of the Program.

The draft Review was provided to the Review Steering Group in March 2008. The key findings and summary of sound practice were presented at a workshop held in Sydney in April 2008 to prepare the metropolitan Area Health Services that had received funds to employ Trainees in 2008–09. The workshop was also attended by Area Health Services staff members who had been involved in the first phase of the roll-out and interested non-government agencies.

This Review was reliant on the input of many people working in Mental Health Services in NSW. The Reviewers would like to thank the 55 people from six Area Health Services across NSW and three Aboriginal Medical Services (AMSs) who provided detailed information and stories of their experiences with the Program. Trainees, Aboriginal Mental Health Workers, supervisors, team members, team leaders and managers provided thoughtful and valuable reflections and suggestions for improving and strengthening the Program.

The Review was funded and supported by the Mental Health and Drug & Alcohol Office (MHDAO) of NSW Health. The Review Steering Group included the Manager Prevention and Community Partnerships and the Senior Project Officer Prevention and Community Partnerships in MHDAO, the Director of Greater Western Area Health Service (GWAHS) Mental Health and Drug and Alcohol Services, and the State-wide Coordinator of the Aboriginal Mental Health Workforce Program. We thank them for their guidance and support.

DEFINITIONS OF TERMS

Aboriginal Mental Health Worker Trainees (hereafter referred to as Trainees) are employed by Area Health Services as full-time, non-graduate Aboriginal Mental Health Workers. They are required to undertake three years tertiary study to gain recognised mental health or counselling qualifications. Upon successful completion of both workplace and university components of their training, they are offered full-time positions as Aboriginal Mental Health Workers.

Clinical Leader Aboriginal Mental Health provides support to managers and their staff by way of training, supervision and coordination of clinical, professional and service development.

Clinical Supervisor is a senior clinician responsible for the development and assessment of a Trainee's clinical competence.

Manager is a generic term used for any person responsible for management at the Area Health Service, Cluster, Network, Regional or mental health service levels.

Preceptor is an experienced mental health worker who provides day-to-day training, clinical guidance and support to a Trainee.

Team Leader is the operational manager of the Mental Health and Drug and Alcohol team and is responsible for supervising the Trainees. The team leader may delegate responsibility for the day-to-day supervision of a Trainee. Depending on the size and the make-up of the team, a team leader may also act as a preceptor and/or clinical supervisor.

Tutor is a university graduate who is engaged on contract by the university to support Aboriginal Mental Health Worker Trainees in their academic work.

INTRODUCTION

POLICY FRAMEWORK

In July 2007, the NSW Minister for Aboriginal Affairs and Minister Assisting the Minister for Health (Mental Health), Mr Paul Lynch, launched the *NSW Aboriginal Mental Health and Well Being Policy 2006–2010* at Charles Sturt University (CSU), Wagga Wagga.

The *NSW Aboriginal Mental Health and Well Being Policy 2006–2010* (the Policy) is a framework to guide NSW Health and NSW Area Health Mental Services (AMHSs), in the provision of culturally sensitive and appropriate mental health and social and emotional wellbeing service to the Aboriginal community of NSW.³

The NSW Aboriginal Mental Health Workforce Program... will expand positions for Aboriginal people in specialist mental health services through a supported training and mentorship program.⁴

The policy launch coincided with a residential teaching block for the Bachelor of Health Science (Mental Health) at the university and was attended by Aboriginal Mental Health Worker Trainees employed by NSW Health. They were the first cohort of Trainees to take part in the NSW AMHWTP, an action area within the Aboriginal Workforce Development Strategy of the Policy to build ‘a supported and skilled workforce’.

The NSW Government has allocated more than \$12 million over five years to develop the Aboriginal mental health workforce, with over \$6 million dollars for the employment and training of additional Aboriginal Mental Health

Workers. The recurrent funding in 2006–07 provided for two Trainee positions in each of the four regional and rural Area Health Services—Greater Southern (GSAHS), Hunter New England (HNEAHS), North Coast (NCAHS) and Greater Western (GWAHS)—and one position each to Justice Health and Northern Sydney and Central Coast (NSCCAHS). The next phase of the roll-out is due to commence in 2008–09 and will provide nine positions for mainly metropolitan Area Health Services.

A State-wide Coordinator position has been funded to oversee and support the Training Program, and around \$3 million has been allocated to the Aboriginal Clinical Leadership Program for employing Clinical Leaders in Aboriginal Mental Health in some Area Health Services. An additional 10 Aboriginal Mental Health Worker positions are being allocated to ACCHSs funded by the NSW Government in 2008. These additional positions add to an existing workforce of more than 50 positions in Area Mental Health Services and 15 in the ACCHSs funded by the NSW Government. Funding of the additional positions is part of the implementation of *A New Direction for NSW: State Health Plan towards 2010* and *NSW: A New Direction for Mental Health*.

Aboriginal workforce

Increase the number of Aboriginal staff in the NSW Health workforce and create an environment that respects Aboriginal heritage and cultural values. Increase the number of Aboriginal people in university health courses and cadetships. Identify opportunities for skills and career development for Aboriginal staff to work in a range of health-related roles.⁵

³ *NSW Aboriginal Mental Health and Well Being Policy 2006–2010*, Summary, page 1.

⁴ *ibid.*, page 27.

⁵ *A New Direction for NSW: State Health Plan towards 2010*, NSW Department of Health, page 31.

BACKGROUND

HISTORY

It has been well recognised, documented and acknowledged by governments that the burden of mental and physical distress in Aboriginal communities has a myriad of negative impacts on the mental health and social and emotional wellbeing of Aboriginal people. It has also been clear that Aboriginal people are not accessing mental health services at a rate commensurate with the levels of distress. One strategy to improve access to mental health care is to increase the number of Aboriginal Mental Health Workers.

The need for improvement in the mental health and social and emotional wellbeing of Aboriginal people has been highlighted in many reports... The complexity of needs prevalent in Aboriginal communities presents a significant challenge to health services... the *NSW Aboriginal Mental Health and Well Being Policy 2006–2010* focuses on the specific role of the NSW Health specialist mental health services.⁶ The Policy further strengthens the partnership between Area Health Services and ACCHSs.⁷

Early days

The current Training Program had its beginning in 1993–94 with the development of the Koori Mental Health Outreach Workers Training Program, a Rural Health Support Education and Training-funded pilot project to provide mental

health training for Aboriginal people.⁸ It had three aims in educating trainees: to develop the appropriate knowledge, skills and attitudes to be able to work as Aboriginal Mental Health Workers; to develop skills so that they can work effectively in a community mental health setting; and to develop the skills to assist communities to identify mental health needs and initiate primary prevention and early intervention programs.

It was originally a two-year training program based at Queanbeyan Mental Health Service with five trainee Aboriginal Mental Health Workers. Four trainees completed the course and graduated in December 1995. All graduates were invited to apply for three available Aboriginal Mental Health Worker positions (graduate level) in Southern Area Health Service, and three were appointed on a merit selection basis.

In 1995 it moved to larger premises in Goulburn to accommodate about 15 new trainees. It was evaluated in 1996 with the view to seek funding to support ongoing development. By this time, course organisers had gained formal recognition for it. CSU accredited it as an Associate Diploma in Health Science (Mental Health).

The training project continued to develop and receive ongoing funding from the Commonwealth Department of Health and Ageing Office for Aboriginal and Torres Strait Islander Health (OATSIH) and NSW Health (Centre for Mental Health). In 1996–97 NSW Health committed an additional \$180,000 for two years for the recruitment and training of five Aboriginal Mental Health trainees in the Southern Area Health Service. Once the trainees had completed their training, they were not guaranteed a position; however the

⁶ *NSW Aboriginal Mental Health and Well Being Policy 2006–2010*, NSW Department of Health, page 1.

⁷ *ibid.*, page i.

⁸ Rural Health Support Education and Training Grant No. 195 was awarded by the Commonwealth Department of Human Services and Health to the Aboriginal Mental Health Program, Goulburn, NSW (Len Kanowski and Judy Westerway).

four graduates were offered employment in the Area Health Service as Mental Health Workers. Three graduates took up positions.

By 1998, the training project was known as the Djirruwang Aboriginal and Torres Strait Islander Mental Health Education and Training Program, a partnership arrangement between the Southern Health Service (NSW Health), the Djirruwang Steering Committee and CSU.⁹ By this stage, it had been upgraded to a Diploma by CSU and was still operating from premises in Goulburn, NSW. It was evaluated again in order to review progress and to secure funding until 1999–2000.

Recent developments

In 2000, the Djirruwang Program was upgraded to a Bachelor of Health Science (Mental Health) by CSU, which offered the course based at its Wagga Wagga campus. It was popular, with 54 students from Queensland, NSW, ACT and Victoria enrolling in it. During this period, Southern Area Health Service handed the Program over to CSU to offer at its Wagga Wagga campus; OATSIH continued to fund it.

In 2002, the curriculum and course structure were revised, under the guidance of a National Reference Group. Significantly, the new curriculum was based on the *National Practice Standards for the Mental Health Workforce*, 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’.¹⁰

OATSIH contracted the Centre for Rural and Remote Mental Health in collaboration with the New South Wales Institute of Psychiatry to evaluate the Djirruwang Program in 2005–06. One of the major findings was that the Program was perceived to be ‘unique and valuable’. A number of recommendations were made with regard to Program implementation and support, such as increasing the number of Djirruwang Program staff and clarifying CSU’s responsibilities and commitment to the Program.¹¹

Two other Area Health Services—HNEAHS and Far West Area Health Service (FWAHS, now part of GWAHS)—established traineeships. HNEAHS based two Trainees in Child and Adolescent Mental Health at Tamworth with placements at Westmead Children’s Hospital. One graduated from the Djirruwang Program and one in psychology by the end of 2007. During the traineeship, they were supported by an Aboriginal Coordinator.

GWAHS had also established four Trainee positions in 1996, and placed them with mental health and counselling teams in different regional towns. Like other Area Health Services, Trainees were only employed until they graduated, at which time they were encouraged to apply for mental health worker positions. By 2005, GWAHS had a total of eight Trainee positions and employed several successful graduates of the Djirruwang Program.

The GWAHS Training Program won the 2005 NSW Premier’s Award and the 2005 NSW Aboriginal Health Award for Innovative Aboriginal and Career Development Programs. It was during this period that the

⁹ Djirruwang means ‘light’ in the language of the Ngunnawal people, the traditional owners of the area.

¹⁰ Brideson, T and Kanowski, L (2004). ‘The struggle for systematic adulthood for Aboriginal Mental Health in the mainstream: The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program’, *Australian e-Journal for the Advancement of Mental Health*, Vol. 3(3), page 211.

¹¹ Grosvenor, J, Montague, R, Toomey, T and Glover, R (2006). *Djirruwang Program External Evaluation*, Centre for Rural and Remote Mental Health, University of Newcastle and The New South Wales Institute of Psychiatry, Orange, NSW.



Charles Sturt University 1st year students, 2007

Director of Mental Health and Drug and Alcohol secured recurrent funding for the Trainee positions. Trainees who successfully completed the Djirruwang Program and performed satisfactorily in the workplace were guaranteed a position as an Aboriginal Mental Health Worker with the mental health team that trained them.

In 2006, GWAHS engaged the Cooperative Research Centre for Aboriginal Health (CRAH) to work with mental health and drug and alcohol staff in the former FWAHS to document the Training Program and develop the *Aboriginal Mental Health Worker Training Program Manual* as a resource for all staff involved in the Program. The Program rationale, aim, objectives and strengths were agreed upon by participating staff as part of the *Manual* development process.¹²

¹² Watson, C and Harrison, N (2006). *Aboriginal Mental Health Worker Training Program Manual*, Cooperative Research Centre for Aboriginal Health, Darwin, pages 12–13.

STATE-WIDE ABORIGINAL MENTAL HEALTH WORKER TRAINING PROGRAM

NSW Health has built on the successes of the (former) Far West Aboriginal Mental Health Workforce Development Program to establish the State-wide AMHWTP.

Program rationale

By employing and training Aboriginal people who know the community and who are likely to stay in the community, the AMHWTP seeks to:

- break down barriers and increase accessibility of mental health services for Aboriginal communities
- address health workforce shortage in remote areas
- enhance cultural appropriateness of mental health services
- improve workforce retention
- increase awareness of local issues affecting the local community
- build communities' capacity to respond to their mental health needs
- provide role models and mentors for local youth
- create cultural awareness overall.

Objectives

The Program aims to improve the mental health and wellbeing of people, especially Aboriginal people, by meeting the following objectives:

- Increase the number of qualified Aboriginal Mental Health Workers in the workforce.
- Increase the number of Aboriginal people accessing mental health services.
- Increase the knowledge of mental health services staff about the health beliefs and needs of Aboriginal people.
- Improve the responsiveness of mental health services to the needs of Aboriginal consumers.
- Improve the effectiveness of prevention, early detection, intervention and treatment services for Aboriginal people and communities.
- Increase the opportunities for local Aboriginal people to undertake supported practical and theoretical training in mental health and drug and alcohol.

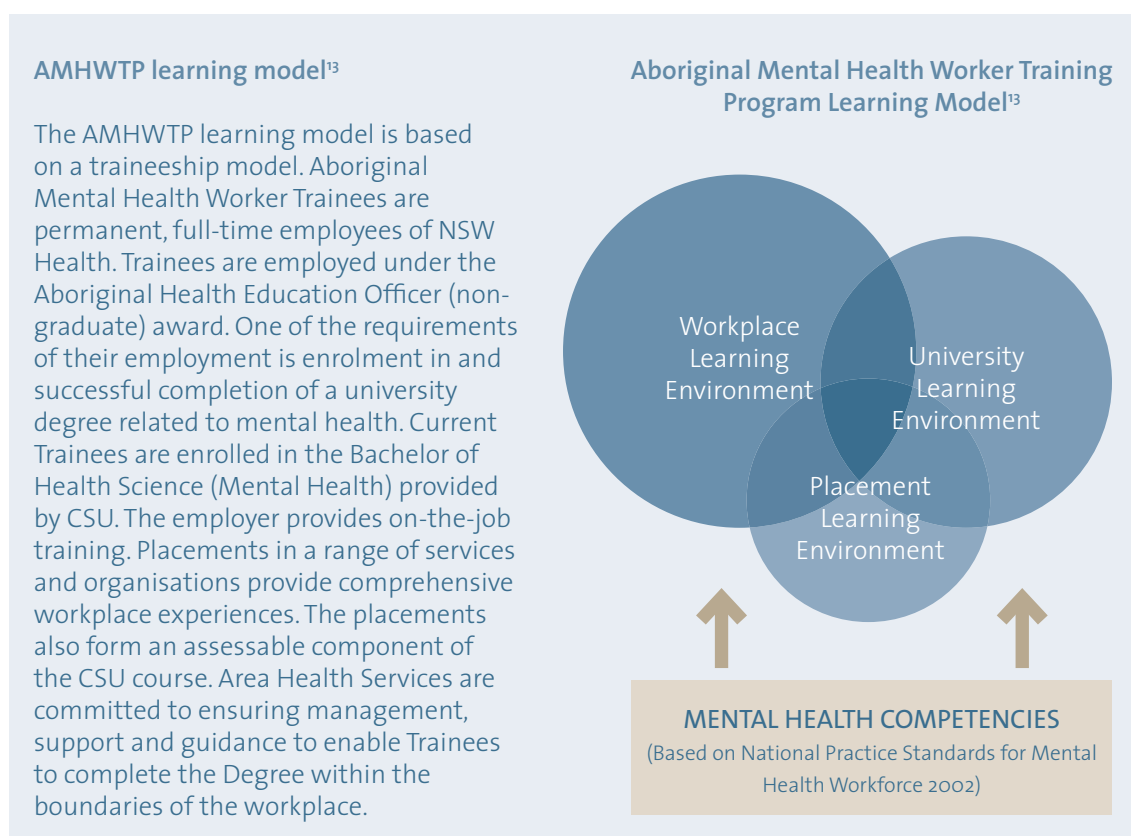
Program strengths

On a philosophical level there are a number of strengths underpinning the Program:

- It builds community capacity by training local people.
- It increases the number of Aboriginal people working in the mainstream mental health and drug and alcohol system.
- It ensures that the mental health workforce has the appropriate proportion of Aboriginal staff.
- Aboriginal employees are cultural awareness ambassadors. They contribute to the development of a service that is supportive of Aboriginal culture and aspirations.
- Permanent positions are created in the health service for Aboriginal people who successfully complete training.

Description of State-wide Aboriginal Mental Health Worker Training Program

The GWAHS Training Program served as the model for the State-wide Program.



Description of State-wide implementation process

The Training Program is being introduced into Area Health Services in two phases. The first funding allocation for 10 positions went as a priority primarily to rural Area Health Services in 2006–07, along with a position for the State-wide Coordinator of the Program. The second allocation for the remaining nine positions in 2008–09 is mainly going to metropolitan Area Health Services.

MHDAO has allocated funding to each participating Area Health Service to employ two Aboriginal Mental Health Workers. They are recruited as Trainees and are supported in acquiring a recognised degree relevant to mental health work as a condition of employment. The particular university or training facility can be agreed between the Area Health Service and Trainee depending on the need. Currently CSU is the key partner and a Memorandum of Understanding is being drawn up between NSW Health and CSU, but other training organisations could be a partner.

¹³ Adapted from the GWAHS learning model in Watson, C and Harrison, N (2006). *Aboriginal Mental Health Worker Training Program Manual*, CRCAH, Darwin, page 15.

The Trainees are supported through an integrated system of on-the-job training, supervision and various kinds of support. On successful completion of the degree and satisfactory performance at work, the Trainee becomes a permanent employee at the graduate level of the mental health service.

The funding allocation covers operational costs such as Higher Education Contribution Scheme (HECS) fees, computer, and other associated expenses. Trainees are also eligible for AbStudy to fund travel and accommodation while undertaking residential teaching blocks and Department of Education, Science and Training funding for tutors.

Governance

The Program is overseen by a Reference Group comprised of both Aboriginal and non-Aboriginal representatives from the Area Health Services participating in phase one of the Program, and key stakeholders from the MHDAO, Centre for Aboriginal Health and Workforce Development and Leadership Branches within NSW Health. This group is required to report to the Mental Health Program Council via the Continuing Care, Rehabilitation and Recovery Working Group.^{14 15}

In this first phase, the Coordinator of the Djirruwang Program is also a member, and inclusion enables information exchange between the university and Training Program stakeholders. The GWAHS Director of Mental Health and Drug and Alcohol chairs the Reference Group meetings. The CRCAH provides an advisory and support role to the Program.

There is a dedicated NSW State-wide Coordinator for the Program. Based in GWAHS, the Coordinator works with Area

Health Services, the MHDAO, and all other stakeholders to support and oversee the development of the Program and is guided by the Reference Group. Until this position could be filled, GWAHS engaged the CRCAH to fulfil the State-wide coordination role from October 2006 until March 2007 when it handed over this role to the State-wide Coordinator Aboriginal Mental Health Workforce Program. Since November 2007 there has been additional administrative support available to the Coordinator and the Reference Group.

Reference Group activities

The first face-to-face meeting was a workshop facilitated by CRCAH that provided participants with:¹⁶

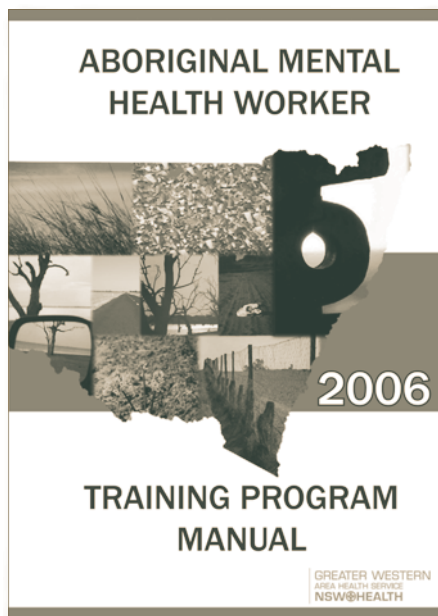
- a detailed overview of the GWAHS experience developing and implementing the AMHWTP;
- discussion of the challenges of implementing the Program;
- a detailed overview of the *Manual* developed to support the Program;
- discussion of what needs to be in place to implement the Program in each Area Health Service, including clarification of the roles and responsibilities of the people involved; and
- clarification of timelines and milestones for implementation, and support requirements.

Given the pressing timeline for recruitment, the Reference Group made two important decisions after attending the November workshop: (1) to adopt the AMHWTP Learning Model developed by GWAHS and (2) to use CSU as the educational provider for the first phase of implementation, specifically the Bachelor of Health Science (Mental Health) conducted by

¹⁴ Enhancement Funding Notification 2006/07.

¹⁵ See Appendix 1 for an overview of governance and relationships of the Program.

¹⁶ The meeting was held on 29 November 2006 in Orange, NSW.



the Djirruwang Program. Each participant was provided with a copy of the *GWAHS Training Manual* as a resource.

These decisions were based on the reality that the GWAHS model was documented, it had a resource supporting it and it had been reported to be having an impact. The Djirruwang Program had been graduating Aboriginal Mental Health Workers for a number of years and was acknowledged to be valuable. Furthermore it was recognised that there was no time to identify alternative models or courses that could accommodate the Trainees as students for the coming year. In addition, it was agreed there would be advantages for the Trainees to attend the same university as a cohort for this first phase of Training Program implementation.

Following the workshop, several Reference Group members converted unfilled Aboriginal Mental Health Worker positions to Trainee positions; GSAHS converted nine positions, GWAHS three positions and HNEAHS one position. From a State-wide funding allocation

for 10 positions, a total of 23 Trainee positions were created, providing participating Area Health Services with an unprecedented opportunity to increase the number of Aboriginal Mental Health Workers in areas of high need. Twenty of these positions were filled.

Throughout 2007, the Reference Group met as scheduled, providing a forum in which Program progress was monitored, information exchanged, issues clarified and peer support provided. It met fortnightly by teleconference from 1 November 2006 to April 2007 and then monthly until December 2007. Face-to-face meetings were held in November 2006, July and December 2007. The Reference Group continues to meet monthly.

CRAH's role

The CRAH undertook to visit each of the Area Health Services upon request to provide an overview of the Program to Mental Health staff who would be working with Trainees, and to clarify and problem-solve any anticipated challenges and issues. CRAH staff, a MHDAO senior project officer and the State-wide Coordinator were invited to provide information and support visits to GSAHS (Team Leaders Workshop, February 2007), Justice Health, NCAHS and NSCCAHS (Mental Health Teams, April 2007). CRAH has provided ongoing support for coordination, particularly through the provision of secretariat services to the Reference Group.

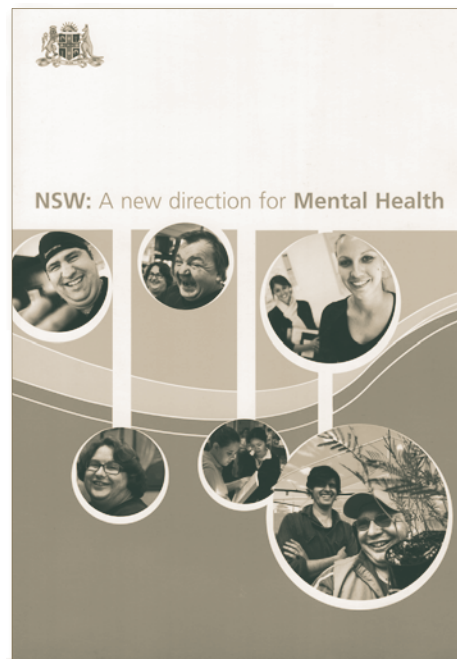
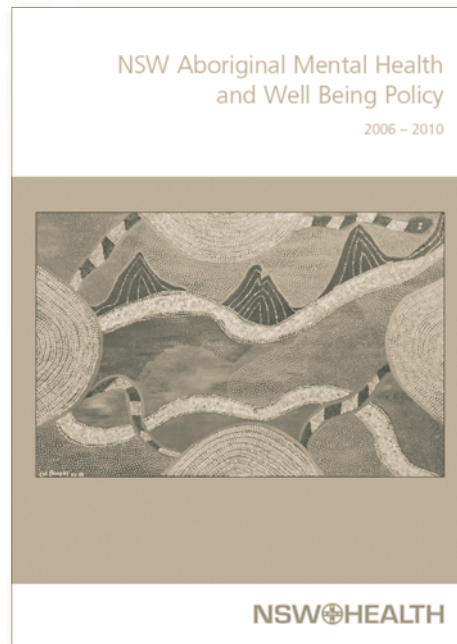
In late 2007, MHDAO engaged the CRAH to review the first year of Program implementation and collect illustrative 'stories' from Trainees and support staff. During the review process, CRAH staff took the opportunity to provide information, to direct interviewees to resources, and to affirm sound workforce development and management practices. See the Methodology section.

PURPOSE OF THIS REVIEW

This Review documents the events of the first year of the Training Program, and the processes and structures that have been put into place to implement the Program. Sound practices, with examples, are highlighted and challenges are identified. These are based on the experiences and reflections of Program participants. Particular points are made through the use of case stories as told by participants.

This review has characteristics of both a formative evaluation and a process evaluation in relation to its purpose and the questions asked. It serves several purposes:

- It affirms the sound practice of mental health managers and teams currently implementing the Program, and provides guidance for improving practice.
- It points the way to successful implementation for Area Health Services that will be putting the Program into place in 2008–09.
- It identifies challenges and issues that caused difficulties for Program participants and suggests ways to overcome some of these.
- It provides future policy-makers, program planners and evaluators with a record of the Training Program's history.
- It identifies critical success factors for implementing this type of workforce development program within a health service context in the current environment of staff shortages.



METHODOLOGY

QUALITATIVE DATA COLLECTION AND ANALYSIS

Document analysis

A number of documents were reviewed including Reference Group Meeting Minutes, evaluations of previous Aboriginal Mental Health Worker Training Programs, and policy documents. These provided information about the history and context of the current Program.¹⁷

Interviews

The Reviewers conducted semi-structured interviews with a range of mental health staff and AMS personnel during November and December 2007. The Reviewers organised site visits to each of the locations where Trainee positions were placed or organised to interview people at venues convenient to them. The majority of interviews were conducted face to face, either individually or in groups; some were conducted by phone. Fifty-five people in total across five Area Health Services and three ACCHSs were interviewed, including one-to-one interviews with 14 Trainees.

The interviews were tailored to respondents' experiences with the Program, with questions being drawn from a questionnaire sent to the interviewees prior to the interview. With interviewees' permission, Reviewers taped the interviews for transcription. These data were organised into agreed categories and emerging themes were identified.

Case stories¹⁸

The Reviewers developed case stories to illustrate particular points and to 'give voice' to Program participants, allowing them to express their views in their own words. Participants were guaranteed anonymity with the understanding that quotes and case stories that could identify them would be sent back for checking and for permission to include them in the public version of the review.

FORMATIVE EVALUATION

Ongoing program development

During the process of interviewing Program participants, the Reviewers became aware that some participants either did not have access to all the available information about the Program or were misinformed about some aspects of it. In some locations, participants were struggling with some of the same challenges and issues that other mental health teams had faced and, in some cases, overcome.

As Reviewers had been involved in the development of the *GWAHS Training Manual*, support for the Reference Group and early Program implementation, they were able to fill information gaps, correct misunderstandings and share solutions. In this respect, the review process provided an opportunity for participants to surface assumptions and problems and for the Reviewers to facilitate ongoing Program development and service improvements.

¹⁷ See Bibliography.

¹⁸ This method is an adaptation based on the work of Ronald Labonte and Joan Feather, 1996.

The Reviewers also alerted the State-wide Coordinator and the MHDAO about areas where timely interventions could avert problems or where additional support was needed and would be appreciated.

REPORT STRUCTURE

This Review is structured to take the reader through the process of implementing the Training Program from workplace preparation, through recruitment, to establishing workplace training and support. It documents the factors that need to be considered, and relates what has worked well for Trainees and teams and what can be considered to be ‘sound practice’. The Training Program requirements of combining study with on-the-job training presented a number of challenges for participants and these are documented along with some examples of how to overcome them.

Highlights of the traineeship for Trainees and for Mental Health Staff and benefits of the Training Program for a range of stakeholders are presented. Some challenges for action conclude this Review.



NSW Area Health Services



Metropolitan Area Health Services

WORKPLACE PREPARATION

Assessing the capacity of a mental health team to support the professional development of a Trainee is the first step when deciding where to locate a Trainee position. Other considerations are the composition and type of the mental health service. The importance of briefing the team prior to employing the Trainee and preparing a workspace for the Trainee are also discussed.

SUMMARY OF SOUND PRACTICE IN WORKPLACE PREPARATION

- It is important for Managers to have a process for assessing a mental health team's capacity to incorporate a Trainee into the team to ensure that the Trainee will be well supported.
- Mental health teams with the capacity to support a Trainee described the Trainee as fitting in with the overall work of the team. These teams usually had six or more staff, at least two of whom were senior clinicians.
- Multidisciplinary teams were able to offer Trainees varied experiences and different occupational perspectives.
- Community mental health teams provided Trainees with the opportunity to observe the range of mental health services from prevention to acute care, home and in-patient visits.
- Support staff who had been briefed about the aim and objectives of the Program, the role and expectations of the Trainee and their roles and responsibilities in training and supporting the Trainee, reported more positive experiences than those who were not thoroughly briefed.

- In teams that had prepared an office space and identified support people beforehand, Trainees reported feeling welcomed and supported.

Assessment of team capacity

There was no apparent systematic procedure for identifying which mental health teams had the capacity to support a Trainee's professional development. Certainly the need to provide a more responsive and appropriate service to Aboriginal clients was recognised and the size of the Aboriginal population in the service's catchment was a consideration. Not undertaking this important first step led to some difficulties for some teams. Managers who had considered a team's capacity identified such factors as the size of the team and the number of senior clinicians as being important to ensure the Trainee would be well supported.

Mental health team location

In several cases team leaders described having advocated for an Aboriginal Mental Health Worker position for several years and 'putting up their hands' when the Traineeships became available (for example, NCAHS). In other cases, the need was apparent and there was wide agreement that a position was essential to meet client needs (for example, Justice Health). In these cases, careful thought was given to where best to place the Trainee and the supports required.

Three of the Area Health Services took the opportunity to convert unfilled Aboriginal Mental Health Worker positions to Trainee positions to make them more attractive. In these cases, teams who previously had an unfilled, permanent position *ipso facto* got



Trainee and members of the Northern Sydney Central Coast Area Health Service

a Trainee position. Primarily because of the size of the teams, this method of allocating a Trainee position did cause difficulties in some cases.

In some Area Health Services Trainee positions were allocated to mental health teams with minimal consultation or discussion about what needed to be in place, such as enough staff to support the Trainee's professional development. In one case, a team that was not represented on the recruitment panel did not realise that the new Aboriginal worker was actually a Trainee; in another case, the Trainee was reported to have 'just appeared' in the workplace. These circumstances proved difficult both for Trainees and teams.

Mental health team size, composition and service type

In larger teams of six or more with several senior clinicians, interviewees described absorbing the Trainee's professional development into the team's work. Some senior clinicians had previously undertaken clinical supervisor and/or preceptor training, and had considerable experience with students. In these teams, Trainees were exposed to several different people's work style,

and their development became the team's responsibility rather than one person's.

In small teams, there were problems if one or more staff members left and their positions could not immediately be filled. In one extreme example, in a team of four staff, two staff members left for different reasons within a short time, leaving the Trainee and one inexperienced worker.

Having a Trainee also put considerable pressures on small teams in terms of time management. In larger teams, the Trainee could be assigned to different workers over a week, thereby sharing the responsibility and lessening the time one person needed to commit to training. Most support staff reported underestimating the time and effort it takes to train a person on the job, particularly someone with no prior health experience and perhaps limited educational attainment. Currently, the time staff members spend in a training activity is not being recorded and, therefore, this considerable time commitment is not being recognised at the system level.

Multidisciplinary teams—comprised of clinicians trained in the different disciplines such as social work, psychology, nursing, occupational and diversional therapies—



Aboriginal Mental Health Trainees in Greater Southern Area Health Service

provided the opportunity for Trainees to be exposed to the range of professional practices and perspectives. Trainees placed in teams made up of clinicians from one or two professional groups, such as nurses and doctors, found that the only exposure they had to other professional groups was incidentally through work or through their placements.

Community mental health teams were able to offer a wide range of professional practice experience to Trainees. One Preceptor described the workplace experience to which the first-year Trainee was being exposed:

So between us, a real mixture of nursing and occupational therapists so the Trainee observes various, different day-to-day activities that will encompass the whole of a mental health client... We're a non-acute service but we have a lot of clients that do become quite acutely unwell, so he's had time coming with us to in-patient services as well and is involved with aspects of the Mental Health Act. Really anything that I do, the Trainee is involved with so he's with us all day and if someone else has got anything more interesting on, we pass it on and he's quite happy to be involved in these kinds of things.

I think you don't learn unless you're seeing and doing... We do ward rounds at the hospital with the doctors and it's a multidisciplinary unit. So we have the psychiatrists, we have the junior doctors, we have the psychologists, the social workers, we have the nurses, the occupational therapists, anybody that's involved on the ward, they're at these two meetings once a week. When it's my month to do it, then I just get the Trainee to meet me at the hospital so he sits in. Whether we've got clients [who are] in-patient at that time, we still always send a member of our staff up there so he's involved in that discussion... Mental Health Act—he's a bit involved in the tribunals, from paperwork right through to actually being there with the tribunal. Everything and anything, he's getting exposed to.

Working in either an in-patient or health promotion setting presented unanticipated challenges to both the Trainee and the team. In the first case, the Trainee is being exposed primarily to treatment of acutely unwell clients to the point of discharge from the in-patient unit; and, in the second case, the Trainee is focussing on promoting the mental health of the whole community and the prevention and

early detection of mental health problems. Both are specialist areas and at either end of the mental health intervention spectrum. Careful consideration needs to be given to ensuring Trainees gain broader mental health workplace experience through placements in multidisciplinary community mental health services.

There are ongoing challenges about the professional recognition and value placed on the health promotion and prevention end of the spectrum and on the Aboriginal view of health. One Trainee described how she felt about her situation:

I feel that I'm very culturally isolated in mental health because it's a clinical environment whereas coming from an Aboriginal environment I always look at the holistic stuff. The holistic stuff and the clinical stuff, they're two different practice models and they don't marry together very well... I know mental health is steering that way [being more holistic in approach], but it is very culturally isolating in the clinical, cold, medicated environment.

Most in-patient units are staffed predominately by nurses and the role of the Aboriginal Mental Health Worker within this setting has yet to be fully defined, making it a particularly challenging workplace environment.

Preparation for the Program

Teams allocated a Trainee position had the opportunity to receive a briefing prior to recruitment from the Coordination. GWAHS made the *Aboriginal Mental Health Worker Training Program Manual* available upon request to other Area Health Services. The *Manual* had been provided to Reference Group Members in hard copy, and GWAHS provided it on CD-ROM in Word format with the view that other Area Health Services could adapt it for their own use.

Most Area Health Services requested briefing visits, just prior to or just after recruitment.

The Coordination Team took staff through the *Manual*, placing emphasis on key areas such as role delineation and expectations of Trainees over the three years of training. Team and Trainee responsibilities were also stressed. In some Area Health Services, Cluster and Area Managers received the briefing and they, in turn, were expected to prepare their mental health teams for having a Trainee and all that it involved.

Those who had not received a briefing about the Program prior to employing a Trainee related feeling in the dark, concerned and anxious. They had questions about roles, responsibilities, expectations, the university and entitlements. They did not fully understand the requirements of the Traineeship regarding the relationship between work and study, the limits of Trainees' capabilities to have a caseload, and the necessity of clinical supervision. Despite a challenging year, team leaders and supervisors responded positively to the concept of the Program and were appreciative for the briefing and offers of assistance and support.

Not having seen the allocation letter, one manager reported she was not aware that the positions were part of a training program. As a result she did not include the training requirement as part of employment in the position description. When asked if, on reflection, there was anything she would have done differently, the Manager replied:

I would have had [the GWAHS] position description... I would have found out more. If I'd known that there was even a thing called a Traineeship Program, I would have been sourcing information about it. You know, basically [we] feel like we've been floating through a darkness. And you know, if I was aware that there were resources that we could have gone to then I would have done that. Yeah, there's probably a whole range of things I would have done extremely differently. I would have done very different things around induction, would have [allocated] supervisors more early on in the piece... So from the word go it becomes clearer because the rest of the staff also need to be

aware of the fact that they need to include the Aboriginal Mental Health Trainees in their assessments and interview processes and then work more closely with them. But it's a bit of a learning curve for everyone on the team. Because I think people on the team have just assumed that they [Trainees] would only sit in with Aboriginal clients and they could look after themselves, so they'd know what to do...

A newly allocated Preceptor reported: *It's a bit of a steep learning curve for everyone. The Trainees are as in the dark as everyone else about what they should and shouldn't do.*

I think that staff have been really keen around the Trainees starting but it's just like we've said before, we've been the blind leading the blind. (Manager)

Mental health teams who had been briefed and were prepared did not identify challenges and issues about the basics of the Program, such as roles and expectations. Their challenges included not being able to spend enough time with the Trainee, bureaucratic barriers and lack of knowledge about the university component. If they experienced problems, they were also able to seek ongoing support from Coordination Team members throughout the year or take issues to the Reference Group.

Preparation for the Trainee

Trainees expressed feeling welcomed and supported when a workspace was allocated (desk, chair, laptop computer, telephone, and other resources), support people identified (clinical supervisor, preceptors, cultural mentor), and an orientation/induction program organised.

I don't know what was supposed to be prepared for me, but I had my mobile phone and my laptop and everything was basically there, straight away... They had everything in place for the induction process for the first couple of weeks, where I was going to be and stuff like

that. So, it was basically set up pretty quick and clearly, which was quite good. (Trainee)

Giving some careful thought about where physically to locate the Trainee can have unexpected benefits.

I guess we thought about where we were going to place her in this building. We didn't want to isolate her; we wanted her in a room where she had some privacy but she was also in with other people. We're fairly tight for space in this building so we put her in a room with two other people at the time and they were two young females, both studying. So it gave her immediate support and I guess we were lucky that the people that were in the room were supportive type people and one of the other girls had only just started as well so they were both the new kids on the block at the same time.

CHALLENGES PREPARING THE WORKPLACE

In some cases, team members were not well briefed about the Training Program, its rationale, aim and objectives and as a result there were tensions around what was viewed as an unfair situation. Trainees, for example, are able to take study leave for residential teaching blocks and had a day per week during the semester allocated for study. In one Area Health Service, enrolled nurses upgrading their qualification to a degree are required to save up all their study leave allocation (two hours per week for approved study), plus take recreational leave to cover residential teaching blocks as well as pay all associated expenses.

Given the high turnover of staff in some areas, it has been a challenge to keep all team members informed about the Program and the Trainees' role and responsibilities. A few interviewees reported tensions arising when a new team member did not know about the Program. In Area Health Services that converted existing Aboriginal Mental Health



Rural western NSW

Worker positions to Trainee positions, there was resistance in some teams to the concept, particularly when the team was short-staffed and feeling pressured.

Most Preceptors reported that they did not appreciate the actual requirements for doing a good job as a Preceptor when they agreed to take on the role. When time was short, the Preceptors stated that they were not able to provide sufficient support for Trainees. The reality is that when short-staffed, direct client care will be the priority.

In some cases, systems blockages, lack of knowledge and misunderstandings about the funding allocated for the Program resulted in: delays in recruitment, with resulting stresses on Trainees and team leaders; the position being advertised under different award levels in different Area Health Services; and delays in receiving laptop computers and other office equipment.

OVERCOMING A CHALLENGE

One manager related how she was able successfully to bring her team around to the idea of supporting a Trainee position:

The challenge that we had here was that we did have the Aboriginal Mental Health position as a clinician and all of a sudden I was telling the team, that it has been converted into a Trainee position. There was a lot of angst from the team, saying, 'Well, we are losing a clinician, you know, we really need clinicians, since we are short staffed'. But it is capacity building, so I said, 'Look, this is an investment for the future to have a Trainee'. So very early, we tried to say that everybody on the team has a part, once a Trainee comes on board, to support and to guide the Trainee... But now, all of the work is on the team who have clearly come on board. They can see the benefits of it, of a Trainee coming through and they are quite happy to support, guide, any sort of assignments... The team has taken ownership of the Trainee process now.

CASE STORY: NCAHS preparation and support for Trainees

Making sure the workplace was prepared and the Trainees were well supported during their first year were priorities for the Network Manager and the Mental Health Network Education and Training Project Officer (NETPO). I think that is really important to set the goalposts and to set the scene well.

The Network Manager described the supportive setting the Trainees were placed in:

The Line Manager is an advocate [for the Traineeship], so is the senior clinician and so is the whole mental health team, because of the nature of the population they deal with they are very aware [of the issues]... Even the psychiatrist was saying you've got to get some Aboriginal Mental Health Workers, we haven't got any and we need them, so the hospital was very supportive as well, and the management, all very helpful.

From the beginning, the Trainees' role was made clear:

The word went out right from the word go, they were not to have any clients, they were not to have any direct responsibility for clients. They were to have contact, they could go and do an assessment but they were not to be held responsible for any clinical work. If they wanted to become involved with the case manager, great, but they're not to be given any responsibility. They are learners and that was made very, very clear...

The Network Manager asked the NETPO to coordinate the program for the Trainees. He explained how he first met with each of them:

Initially, I held a face-to-face meeting with each one of them and I went through their workbooks and manuals and I went through their position descriptions... I asked them what sort of questions they had and what their expectations of the Area Health Service were and laid out what the requirements of the Traineeship were, making sure that was consistent and that both Trainees understood that. I think that is really important to set the goalposts and to set the scene well.

[I let them] know that they were employees of the health service, but they were not to take on a clinical load and that they had a university place that would give them a three-year undergraduate degree at the completion of all this. That they understood that they would have a day off a week to work on their university studies and that we would be assigning preceptors for each one of them who would help them with operational day-to-day tasks, who would be their support. I explained my role and I explained that I was going to be coordinating this program on behalf of the Network Manager and I guess the next step was to form a local steering committee.

A steering committee was established to provide guidance and support for the Trainees. The meetings also provided a formal opportunity for raising and addressing issues. On the committee were the Senior Aboriginal Mental Health Worker, the Aboriginal Network Manager, AMS representative, Line Manager, Network Manager, the two Preceptors and the two Trainees. It was chaired by the NETPO and met quarterly after each of the residential teaching blocks at CSU.

We put on the agenda, just common sort of standard items... things like updates from the Trainees, of course, clinical studies, work placements, things like that, any issues or problems.

What did the Trainees think of the steering committee?

It's been excellent for us because it does provide support and it does give us the opportunity if we do have issues to raise them in the steering committee, and then they get addressed. For me, I think it's a great idea.

It's a great idea because we can follow up things and if we need anything or have any concerns about anything, more support and things like that, we can take it to the meeting—so good feedback in other words.

The two Preceptors were identified once the Trainees joined the Mental Health Extended Care Team. The NETPO explained:

It became obvious that, at a certain point in time, there were two senior clinicians who were not only capable but willing to act in the roles of Preceptors, and the Trainees seemed to be able to relate to them okay.

The Preceptors held regular weekly meetings with the Trainees to discuss clinical issues and they took them on visits to clients. Both were hoping to be able to spend more time with the Trainees on clinical care but due to staff shortages were not able to. The Trainees were able to concentrate on their studies and also go on client visits with other staff. The Preceptors explained:

My perception of this year is that it has been lucky and unlucky in a way, because of the first year being such a huge academic year for them. The focus hasn't been on clinical, which has probably been very, very fortunate for the Trainees, because we just haven't been able to deliver those clinical components really, at the moment.

They have been at times really overwhelmed by the amount of study that's involved. So you are right, in a way it has been fantastic—fortuitous in fact—that they can kind of get knuckled down into that and look and ask without having to even come out all the time with us. We grab them when we can...

The Trainees confirmed that this year had been a big one for them. It had been very important to them to have Preceptors and a day a week to study. One of the Trainees commented:

I think what's working for me is that we have our Preceptors. They are so important. Being able to go to them, chat with them, even about our Uni studies. I think another thing that's important is that we have our study day every Friday so that helps us get things we need to get done for Uni.

The Network Manager and Line Manager also supported the Trainees to extend their learning beyond their university studies:

Whatever comes up with the learning and development, I have told them straight out that 'as long as this relates to your work and it doesn't interfere with your studies, you are welcome to go'. Because I think that it's an opportunity to learn things as they go along. Because of the different things that come up, it also helps with their studies.

They attend our education programs that we run here as well. So anything that is really relevant for them, they are able to attend. And they get plenty of time off for their studies as well.

RECRUITMENT

Local recruitment at the Area Health Service level promotes responsibility from, and ownership by, the local Mental Health Service. Key factors in the successful recruitment to the Trainee positions were: a clearly written position description; involvement of Aboriginal staff and community; and various types and means of advertising the positions. When there was careful consideration of interview panel composition and interview questions, applicants were able to present at their best. Successful applicants demonstrated a solid work history and a willingness to take on the challenges of a Traineeship in mental health.

SUMMARY OF SOUND PRACTICE IN RECRUITMENT

- A good position description clearly stated that the Traineeship encompassed full-time work and full-time study, and that successful performance in both are required for continued employment.
- Area Health Services that used a variety of media (internet, local papers, and Indigenous media) and networks to advertise the Trainee positions received a large number of applications.
- Involving the local Aboriginal community in the recruitment process ensured a positive response to advertisements and willingness to engage in the ongoing support of the Trainees.
- Involvement of the Aboriginal Health Unit in the recruitment process had a number of benefits, including access to Aboriginal expertise and networks and ongoing support for the Program.

- When there was a balanced panel with Aboriginal representation, questions made available before the interview and a comfortable venue, Trainees expressed a positive view of the interview process.
- Allowing sufficient time for the criminal record check and adopting a flexible approach if the suitable applicant had a past criminal record were identified to be important considerations.
- Trainees and their support staff reported a smoother transition to combining work with study when Area Health Services began recruitment processes in time for Trainees to spend at least three months in the workplace before they began university studies.
- Consideration of a Trainee's life, work and study experiences enabled the workplace to put suitable structures and processes into place to support the Trainee's development as a mental health professional.

Position description

Position descriptions that were examined varied greatly in terms of how clearly they spelled out the duties expected of a Trainee and whether they included the key requirements of the Training Program. For example, some did not include the conditions for ongoing employment. Some of the Area Health Services opted to adopt the GWAHS Trainee position description as agreed by the Reference Group; it clearly stated the conditions of the Traineeship. Under 'Summary of Duties', it stated the following study and work requirements:



Hunter New England Area Health Service Community Health Centre

The position will undertake and meet the requirements of the Bachelor of Health Science (Mental Health) degree. Under supervision, the position will participate in the development and implementation of [mental health services] to promote the social and emotional wellbeing of Aboriginal people and the wider community... Continuing employment is subject to satisfactory completion of academic and clinical course requirements and Aboriginal Mental Health Worker Trainee performance targets.¹⁹

The position description also included a detailed 'Statement of Duties' under the headings of Community Development, Service Provision, Professional Standards, Education, and Other Duties.

Trainees reported being employed under different position titles, such as 'Aboriginal Liaison Officer' or 'Aboriginal Mental Health Professional' or 'Aboriginal Mental Health

Worker' rather than the recommended 'Aboriginal Mental Health Worker Trainee'. They were also employed under different classifications, such as Health Education Officer or Aboriginal Health Education Officer. It had been recommended that the classification 'Aboriginal Health Education Officer' be used and the level 'Non Graduate' be specified.

Advertising the position

Most Area Health Services used a variety of media outlets to advertise the position: *Sydney Morning Herald*, the NSW Health website and the NSW Government Job Search. Several also advertised in the *Koori Mail*, *Indigenous Times* and local papers. Trainees reported that they heard about the position in one of four ways: they saw it on the NSW Government intranet or internet website, in the local paper, in the *Koori Mail*, or they heard about it from a colleague, a friend or a family member. No Trainee reported seeing the ad in the *Sydney Morning Herald*.

¹⁹ Watson, C and Harrison, N (2006). *Aboriginal Mental Health Worker Training Program Manual*, CRCIAH, Darwin, Section 2: People.

Involving the local community in recruitment

The case story that follows demonstrates the benefits of involving the local Aboriginal community in recruiting Trainees.

CASE STORY: NCAHS recruitment using networks and involving the local Aboriginal community

NCAHS successfully recruited two applicants to take up the Traineeships. *We had 18 applicants and we interviewed 11 and of those, any of the top six we believe we could have put in places straightaway... How did they get such a positive response?*

The Network Manager, as part of the Mid North Coast Area Health Service, had been working with the local Aboriginal community to identify priorities for the development of mental health services for several years:

The original workshop was back on the 10th of February '04. This was a Mid North Coast Area workshop followed up by meetings in each network and the outcome of that whole thing is where to from now and the next five years. The four priority areas identified were access to mental health [services], recruitment and retention of Aboriginal mental health staff, training and education of Aboriginal mental health staff and defining the roles of any cadets or trainees we have. They were the four priority areas, well that's what the group saw.

When NCAHS was notified that there were two Aboriginal Mental Health Worker Traineeships available, the Network Manager put in a bid for them and was successful:

... When we got the two cadet [Trainee] positions, they wanted one in Kempsey and one in Port. The Elders made it very clear to us when we appointed them, we must have a male and a female and they must be on the same site for support, so that was an issue, particularly as we had to follow the recruitment policy. However, as it turned out we had a male and a female as the best two applicants. The agreement was they be placed in Kempsey, and in hindsight I think it was a wise one, that the two of them had the support and they've got the Senior Mental Health Worker in Port Macquarie who's always there for them and so they get on very, very well... But that was advice from the Elders.

Before the positions were advertised, news of the positions travelled through the informal networks:

... The staff actually went out and spread the word and I think that was part of the reason we got so many applicants, is that the staff were telling people that these two positions were coming up. There's probably a population of around 50 odd Aboriginal health workers within Port Macquarie, Kempsey, with the courts and youth justice and education, DoCS and all the different government departments and they meet regularly and they tell each other what's going on... so there's that informal education, informal process in being a smaller town... And I told one of the Elders, the best communicator you can find in town.

Local groups were keen to make sure local people got a say. Aboriginal people were well represented on the interview panel. Besides the Network Manager:



North Coast Area Health Service Aboriginal Mental Health Worker Trainees with colleagues

... We had the Network Manager for Aboriginal Health, we had the Senior Aboriginal Mental Health Worker and the Area Manager for Health Promotion. So there were three Aboriginal people, all from the local area, and myself.

The Network Manager used the position description developed for the GWAHS Trainees as a basis, and sought input from the Aboriginal groups first and also from the interview panel:

... What we did do is we sent it out to all the Aboriginal groups first and got them to tinker with it and play around with it to see that it fitted... our group, what I asked them for was wording that needed to go into the advertisement, to look at the job description and to design a question each.

The Network Manager's assessment at the end of the first year:

... We've got two fine students who are doing extremely well and they have just had so much invested in them by the university, the staff, but their own investment of time has been amazing. They have worked so hard and a lot of that is about their need to do it for their community, for our local people here. And they know that the community has a huge vested interest in them actually getting the best training possible and that's very noticeable on talking to people that the community knows both of them by name and they say they are just two of the finest people that could have been selected.

Involvement of Aboriginal Health Unit in recruitment

The following case story illustrates the advantages of involving the Aboriginal Health Unit in recruiting to Aboriginal positions.

CASE STORY: GSAHS recruits 10 Aboriginal Mental Health Worker Trainee positions

GSAHS took the opportunity to convert eight unfilled Aboriginal Mental Health Worker positions to Trainee positions. With the assistance of the Aboriginal Health Unit, GSAHS advertised 10 positions in one recruitment drive.

GSAHS developed a position description for the Traineeships based on a combination of the GWAHS Trainee position description and the GSAHS Aboriginal Health criteria. The position was set at the Aboriginal Health Education Officer non-graduate level to ensure consistency Area-wide. The selection criteria required that applicants had established links with the Aboriginal community. As explained by the Program Developer/Coordinator Aboriginal Health:

Not only do people need to be of Aboriginal descent, they need to have links within their local community and they need to have an understanding about Aboriginal people and some of the health issues.

The positions were advertised through the local newspapers and the *Indigenous Times*, the *Koori Mail* and local Indigenous networks. Staff promoted the position locally and the Program Developer/Coordinator Aboriginal Health sent information out through her extensive networks. She was the contact person for enquiries about the positions. The Coordinator reported that the advertising effort was very effective:

But our most successful was through the Koori networks, through the emails—sending it out, you know to the list that I had and then just asking people to forward it on and just gave

a bit of blurb about it and attached some information about it. [We] gave them contact details and the other thing was that I was the contact person for the positions and it was clearly indentified that I am an Aboriginal person and so there was a whole stack of phone calls about 'What is it about?' [We had] really informal kinds of discussions.

More than 40 expressions of interest were received for the positions. Information packages for all vacancies were collated and distributed centrally by the Aboriginal Health Unit, with local contact points provided for each position. Prior to the recruitment, the managers were briefed as a group about what needed to be set up for the Trainees. *They needed to have a desk, they needed to have a computer, all of those things needed, you know, for a new employee... Decisions [needed] to be made such as who was their direct line supervisor. A copy of the AMHWTP Manual was also produced for each team that was recruiting a Trainee.*

Local interview panels were convened for each position. The panels were comprised of the mental health area manager, the direct supervisor of the position and an Aboriginal person with health experience. The questions were the same for all of the interviews. Nine of the 10 positions were successfully filled.

An important factor in establishing a large number of Trainee positions in the Area Health Service was the direction provided by the Manager Service Development and Performance Mental Health working in partnership with the Aboriginal Health section to bring mental health teams on board with the Program and the support for the process by the Director Mental Health and the Chief Executive.

When asked what made the recruitment process so successful, the Manager Service Development and Performance Mental Health replied:

I think the way we went about the recruitment and use of the processes had a huge impact on that. We did the paper advertising but [the Program Developer/Coordinator Aboriginal Health] circulated it right through all the Aboriginal organisations. She'd let them know it was coming and she communicated with them so they were expecting it, asked them to think about who might be interested, appropriate to apply and then the ads went out through those organisations. Those organisations worked with people who were interested to get their applications in and

I think that made a huge difference. We had [the Program Developer/Coordinator Aboriginal Health] as the initial contact person for anyone who was interested so they spoke to an Aboriginal person before they spoke to a mental health service.

And I think the preparation around the interviews, talking to the people who would be chairing the interview panels about what they needed to be looking for, having a local Aboriginal community representative on each of the interview panels [made it successful].

We just recently advertised the two vacant positions and despite my nagging just did it through the media and websites and we got nothing.

Interview process

Most of the Trainees reported that they had positive interview experiences, though some reported being quite nervous. Trainees identified several factors that made a difference to how they felt they performed at the interview. Having Aboriginal people on the panel was mentioned as a factor that had helped them to feel relaxed.

I just felt comfortable and at home with everyone, because I had a couple of Aboriginal people on my panel and they, you know, knew where I was coming from when I was speaking, so I felt pretty relaxed about that. I felt pretty confident. (Male Trainee)

That [interview process] was actually a really positive experience. I felt really relaxed in there, and I think it was because of the way the panel were... There were two females and two males, and there were two Koori people and two white people. And one was from outside and the other three were within health, mental health. (Female Trainee)

Other factors included having the questions beforehand, a comfortable venue and a positive mental attitude.

I thought, 'Well I'm going in for an interview, I need to show the real me, you know who I really am and why I want to do this job,' so that's what I did, I just walked in there, I answered their questions and I felt very comfortable about the whole interview process. (Trainee)

Criminal record checks

Most Area Health Services reported that one of the most problematic aspects of recruitment was the process of submitting the successful applicant's details for a criminal record check and the time that it took to get results back. In the following case, this process was not clearly explained to successful applicants.

We ring the successful candidates last and we always say to them, 'You are our preferred option, we've got to do the checks and we've got to do all that sort of stuff, please don't resign or

anything,' but they were both so enthusiastic, I think they both sort of went and resigned and it was two months later before we got them on. And that caused financial hardship for them both. They were both absolutely desperate to work but I think they got caught up in the excitement. I didn't do that very well and I must take responsibility for that, even though I did say 'don't resign, don't do anything'. I think they thought once they had employment it was imminently going to start next week and that led to a very sad beginning... (Manager)

Allowing plenty of time for the recruitment process to take place and clearly explaining the processes to applicants can prevent these situations.

Several managers described how they undertook a risk assessment on suitable applicants in the event that they did have a criminal record.

We did get an applicant who was deemed to be suitable under most criteria but their criminal record check was a barrier, they didn't get through that. And I guess that really highlighted for us something that we hadn't really thought about but should have. Because that applicant wasn't the only applicant where we had to basically do a risk assessment around what came up on the criminal record check. So that just made us more aware of the circumstances of Aboriginal people... We looked at the experience that these young people had probably had to date and the opportunities that the Traineeship can provide them and factored that into the risk assessment around what came up on the criminal record checking.

Our HR [Human Resources] people do the criminal record check, they process that and it comes back and then it is actually the operational manager who looks at what's come back and does that risk assessment with our HR people. They talked it through with me but it was a decision between them and the HR Department.(Manager)

Timing of recruitment

Trainees who were able to begin their employment in the workplace at least three months before attending the first university residential teaching block related that it was an important factor in their ability to settle into their work and study. It usually takes about six months in a new workplace to become properly orientated and inducted. Those Trainees who began their employment on the first day of the university residential teaching block found it more difficult to settle into the workplace and develop relationships with their team members.

I think [we] were pretty lucky because I started in the October and Uni didn't start until the end of January so I had that three months to get all my mandatory training ticked off, to get everything sorted, to get to know my way around the community and know where I was up to before I actually had to front the books. These guys [who began their employment on the first day of the university residential teaching block] hit the ground, they hit the books, they hit mandatory training, and it was just like smack, smack, smack, it was like you know, bugs on a windscreen literally and they just didn't know which way was up. And you don't [get to be part of the team] because you're too busy doing mandatory training and, you know, you'll hear them go 'oh, they're not here again, they've all got training again'. (Trainee)

Given the length of time it took for the whole recruitment process, careful planning was needed to ensure Trainees were employed by 1 October to allow for enrolment in a university course and about three months in the workplace before university began.

A challenging year

Many Trainees reported that they were attracted to the position because it offered full-time employment and support to gain a degree. It was acknowledged by most Trainees to be a very challenging year. They were required to: learn about a new workplace; the bureaucratic structure, processes and rules of NSW Health; the mental health discipline with its own language and legal requirements; and how to study at the university level. Most Trainees had not worked in a major government department like NSW Health before and most had not studied at the university level.²⁰

In addition, some Trainees had demanding personal circumstances. These included being a single parent or a grandparent raising a young grandchild, being the sole wage earner for a young family, looking after young children or caring for a partner with a chronic condition.

Trainees who had previous exposure to higher education, a solid work history, particularly in some area of government, and a mature approach to challenges were better able to cope with combining work and study and remain positive.

Consideration of a Trainee's life, work and study experiences will enable the workplace to put suitable structures and processes into place to support the Trainee's development as a mental health professional. See the section on 'Workplace Support' for sound practice.

CHALLENGES RECRUITING TRAINEES

Some of the challenges of the recruiting process have already been identified: the chance that suitable applicants may have a criminal record and the timing of recruitment to ensure Trainees have time to be orientated and inducted.

An unexpected set of challenges came up for those mental health services that recruited current employees, some of whom were already enrolled in the Djirruwang Program, into Trainee positions. Each case had particular issues. The two challenges brought to the Reviewer's attention related to: (1) transferring an employee who was being paid under a particular award into a Trainee position without jeopardising the person financially; and (2) recognising and treating the employee as a 'Trainee' when he or she had been operating, for example, as an Aboriginal Mental Health Worker or as an Enrolled Nurse, sometimes with considerable client responsibilities and autonomy.

Trainees who had transferred into the position related how they had to argue strongly for maintaining their salary level. One Trainee had been assured that he would not be disadvantaged but found after transferring that his salary had been cut by several thousand dollars. Team Leaders had to 'go to battle' with workforce development over the matter.

²⁰ Appendix 2: Demographic Profile 2007 Trainee Cohort.



Greater Western Area Health Service Trainees and Managers

As Trainees, previously autonomous clinicians or workers were now aware that they needed to be mindful of their 'unqualified' status.

I often have to say, 'Hang on, I'm still a liability because I haven't got a piece of paper yet.' You know, so I'm always having to remind them.

The fact that you come across as a mature age student [means] you have to do your own gatekeeping because you come across as a confident person. You've still got to remember that legally you're a Trainee and you're still unqualified... they'd say, 'Yep, you can go and do that'. And then I'd say, 'But hang on, I'm not qualified to deal with psychosis yet. I haven't learnt enough about it'. Oh so it was really interesting that a lot of the time because our workplaces are very stretched and resources limited that things are put to us to do more than what our jobs are. You know like they'll say, 'Oh well, you know that bloke down there, you go and deal with him' and you know, you mightn't know about his illness properly so you always sort of have to go, 'Well hang on, can someone come with me because I'm not up on what's happening'.

One Trainee related how the team did not know what to do with her until they received a copy of the *GWAHS Training Manual*:

No one in my workplace knew what I could and couldn't do. It's taken six months for them to give me a meeting to say, 'You can do this and you can do that now'... I've only just received my Manual about what to do... My team were heaps good in helping me as much as they could... It was a bit of a limbo time.

In each case the recruitment of current employees to the Training Program created issues for both the Trainees and their managers around their change in role and responsibilities. There is a need for the development of policies and procedures about how to manage such a transition from worker to Trainee.

WORKPLACE TRAINING AND SUPPORT

The workplace is the primary place of learning and professional development for the Trainee so high-quality training and support from the mental health team are critical to the development of a competent Aboriginal Mental Health Worker. This section discusses the variety of supports established for the Trainees and team members and some of the challenges faced.

SUMMARY OF SOUND PRACTICE IN WORKPLACE TRAINING AND SUPPORT

- The Traineeship was working best in teams where the managers and team members understood the Program aim, objectives and expectations.
- Managers that established clear boundaries around what Trainees could do at any given time in the Traineeship provided a safe working environment.
- Area Health Services that allocated experienced preceptors and clinical supervisors to the Trainees were providing a high level of on-the-job training for the Trainees.
- A thorough orientation and induction process during the first three months provided a good foundation for Trainees to learn about mental health, the workplace and the related community organisations and services.
- The *Aboriginal Mental Health Worker Training Program Manual* was reported to be valuable in providing guidance.
- It was reported to be important for teams to know they had policy direction and support for the Training Program from the Minister, senior management, the State-wide Coordinator and the Reference Group.

- Area Health Services that established formal groups or mechanisms to guide the operation of the Program were able to provide support both to the Trainees and their managers.
- A wide range of informal supports were being provided to Trainees, or Trainees were organising them for themselves.
- Cultural mentors provided important additional support and guidance for Trainees inside and outside the workplace.
- Documentation of training and support activities, including time allocated to the Traineeship, was important for monitoring and evaluation.

Teams understand and support the Program

The Traineeship was working best in teams where the managers and team members understood the Program aim, objectives and expectations. A good understanding of the Program at the management and team level ensured the Trainee was provided the necessary balance of support and work experiences, and ensured clear boundaries were set for the Traineeship.

Managers and Team Leaders spoke about how they had guided and assisted Trainees to establish boundaries and, in some cases, reinforced these boundaries when Trainees were under pressure from community and family members.

And I remember having a talk with [Trainee] about never counselling a friend, because once you find out their deep, dark secrets, you are then a threat to them, because you could embarrass them with other people, so then you will get isolated. So always refer friends to someone else. (Manager)

We put in reinforcing ground rules, because their community knows that they work here and they just think they have got access to them. They have certainly been protected from it, without a doubt. And sometimes we have Indigenous people in-patients and they will be wandering around and they will see [Trainee] and they know her and they will just say, 'Can I go out and see [Trainee]?' And you have to say, 'No, no.' And we have just got to do it nicely, calmly and positively. Sort of setting down those ground rules and it is not Trainees' fault. (Team Leader)

Orientating the team members to the Program could prevent concerns and misunderstandings about the intention of the Program, roles and responsibilities of Trainees and team members, benefits of the Program and entitlements due to the Trainees. See 'Case Story: GSAHS network of support', later in this section for team preparation.

Preceptors and clinical supervisors

Area Health Services that allocated experienced preceptors and clinical supervisors to the Trainees were providing a high level of on-the-job training for them. Preceptors and supervisors with training skills were the most confident providers of training, support and supervision. See the Justice Health Case Story, later in this section, for a good example of the value of assigning a dedicated preceptor to the Trainee.

Other professionals within the mental health service were engaging with the Trainees in a range of ways. In a number of services, visiting or local psychiatrists or psychologists provided education and clinical supervision. Some Trainees had access to formal supervision on a fortnightly or monthly basis.

The Reviewers identified cases where team members who were not formally allocated as preceptors or clinical supervisors nonetheless provided training and support. In the following example, a team member described how he and others in his team who did not have formal roles as supervisors or preceptors involved the Trainee in their client contact work.

He definitely goes out with other team members; in fact he was just going out now as I walked down here with another team member. Look, by sheer default by the fact that [the allocated clinical supervisor] has been taken away from work in the last two to three months, I am [providing support] at this point in time... He's sharing an office with someone, probably he spends a good deal of time too with her, more than I know, just by the fact that he's around her and she would be doing her own client contact work as well.

He gets the full range of experience here. For example, he came out with us when we did a home visit and gave a client an injection and so he saw it. [He has] done home visits with psychiatrists and CMOs before, sat in on meetings with clients and the CMO or psychiatrist. And then, he gets to discuss cases with me. (Team Member)

Several Trainees expressed the need for formal supervision by a skilled Aboriginal worker.

Because I'm the only Aboriginal worker in my workplace, I think I need an Aboriginal supervisor in the health area where I can get support. Because sometimes I ask questions to a person from work and they're like, 'What the heck are you talking about?' or they don't really know much about Aboriginal health... That's probably one of the hardest things, is the loneliness, like you're sitting out here like a shag on a rock. (Trainee)

Orientation and induction

The first three months of the Traineeship is the optimum time for Trainees to be orientated to NSW Health, the mental health service and community organisations and services, as well as inducted into the day-to-day operations of the workplace. In some services a thorough orientation was undertaken; in other services it was ad hoc. Trainees reported that the first three months were difficult if they were left sitting around with little to do. Most of the Trainees were new to the public service, and required support to understand its rules and processes.

What I've realised is that, because of the level of his (in)experience previously in work environments, that I need to work with him on workplace etiquette about who you tell when you're not going to be there and anticipate some things rather than tell us later. And just administrative things like timesheets because he's regularly making errors in keeping his timesheets. So I've just agreed with him that he's going to send a timesheet to me a little earlier and that he will initiate it rather than me having to call him to remind him about it. So I got him to write that in his diary and hopefully it will allow me [time] to look at it and then talk to him about how it might need to be changed. So there's sort of some skill development in just being a worker and knowing about rostered days off and those sorts of things. (Manager)

Both mental health staff and Trainees suggested that services establish a structured approach to the first three months of the Traineeship. This time could be used for orientation programs, mandatory training, and formal induction into workplace policies and practices, roles and responsibilities. It was suggested that formalised sessions on the codes of conduct and confidentiality be conducted to thoroughly inform Trainees of their legal obligations as NSW Health employees. A consequence of a breach may be dismissal from the Department.

While the Trainees [are] in their first year and they're not having a lot of clinical contact, I would utilise supervision to address those policies and procedures. 'We're going to have supervision next week, [and] we're going to talk about this: 'Have you had a problem this week?' And they'll say, 'Well, I couldn't to that.' 'Well you know there is a policy to support that, so how about you find it and that way you'll know it next time'. (Trainee)

Interviewees suggested that orientation could include spending time with members of the mental health team, local government departments, the Aboriginal Medical Service, other areas of the health service. Trainees could begin the process of getting to know their local community by developing a community profile which would also assist with one of their university assessment activities.

Treat [getting to know] the bureaucracy like getting to know your community. It's your workplace; it's your sort of new community. You know, who does what and what are the rules about being here. (Trainee)

CASE STORY: Justice Health establishing good orientation, induction and training process

The time spent providing a thorough orientation to the organisation and induction to the workplace is time well spent. *It's easier to do it properly from the start than try to fix it later.*

Justice Health nominated a very experienced senior clinician as the Trainee's preceptor and clinical supervisor. She has had 23 years in the mental health and drug and alcohol fields as well as training to be a preceptor and clinical supervisor. In preparation for the Trainee's arrival, she and the Manager developed an orientation and induction program for him. The formal orientation was about four weeks long and included a three-day mandatory orientation to the Criminal Justice system; the induction process lasted for the first couple of months:

I'd been a supervisor for Uni students in the past and also I'd been a manager where orientation was really important. Because people tend to feel really anxious and not knowing what's happening, at least they can focus on the orientation; it's something written down. So I had all that set up and basically the roster was introducing the Trainee to key people that we anticipated the Trainee would need to have contact with.

For the first couple of months the Trainee was pretty much 'my shadow' and I think that really makes a difference for Trainees, that they've actually got someone as a support because it's that first couple of months where people can get lost—they may just feel really unsupported and I think particularly for someone coming from a different cultural background with the expectations of that role, like they really needed to have a support person.

A lot of it was just kind of debriefing as well as just having someone to talk to about what happened the day before or what their experience of something was.

The Manager took the Trainee through how the bureaucracy works:

I spent a fair bit of time with Trainee in the first couple of weeks talking about processes and the magnitudes of paperwork. I explained that it's not about your position, it's about the bureaucracy of health and this is how we need to do things. So I spent some of that time familiarising him with governance and how it works.

The Trainee reported that Justice Health had everything in place for the orientation and induction process when he arrived:

Basically, I had a supervisor as soon as I walked on board and was told I had a job and that person actually took me to certain places around the metro area and showed me, you know, where I would be working and gave me a quick over-brief each day, on different areas. Which I thought was very good.



Trainee in Justice Health

[My manager] gave me [a copy of the Manual], she has a copy and then I have a folder as well. And then [the manager's] just gone ahead and photocopied all the relevant paperwork bits that are needed and that's in a little separate file. It's easy to get at. I was hooked up to a lot of reading when I first started. Oh, it is very useful, and it can keep you on track about where you're up to and actually there was only a couple of things that were unclear that the Manual couldn't answer, just questions initially, but they were nothing major.

FORMAL SUPPORT AND TRAINING STRUCTURES

Use of the *Aboriginal Mental Health Worker Training Program Manual*

The *Manual* was reported to be important for guiding the Traineeship. Some Services such as NCAHS and GSAHS were in the process of adapting the *Manual* to meet their own requirements. The Reference Group had recommended the development of a State-wide manual.

Use of the *Manual* was variable among mental health services. Some managers and Trainees were either not aware of the existence of the *Manual* or did not have a copy of it. Teams that did not use the *Manual* had not implemented key elements of the Program, and had struggled to understand the Program and to provide the Trainee with a structured on-the-job experience.

Some managers are following the Manual by the letter and some managers have been a little bit flexible with the Manual. Some of them are using it as a guide; some of them are following it to the letter. Some don't even know what the Manual's about. (Trainee)

A Trainee who was provided the *Manual* on her first day at work reflected on its usefulness.

A number of Area Health Services established formal groups or mechanisms to guide the operation of the Program, including: Manager and Trainee support groups; steering groups; identified Clinical Leader Aboriginal Mental Health positions; formal site visits by managers and the State-wide Coordinator; mentor groups; and formal relationships with AMSs.

A number of interviewees expressed the importance to them of knowing that the Training Program was resourced, and had the support of the Minister and policy direction from senior management, the State-wide Coordinator and the State-wide Reference Group.

Two Preceptors had the opportunity to attend the launch of the *Aboriginal Mental Health and Well Being Policy* and the State-wide Reference Group meeting following the launch. They reported the impact of seeing the Training Program in a broader context and the high level support it has:

That was really fascinating and I think what we took out of it is that people there had absolute passion, vision and you know, [and what we were doing was] also respected. We were sort of the ground staff workers, the preceptors and our ideas were validated...

CASE STORY: GSAHS network of support

GSAHS had established a range of support and management mechanisms for managers, supervisors and Trainees.

Workshop to prepare Health Services for a Trainee

Prior to the recruitment to the 10 Trainee positions in GSAHS, a workshop was held with team leaders, managers and support people to prepare the individual services for implementation of the Training Program. The workshop: provided an overview of the objectives of the Program and the State-wide rollout activities; identified what health service teams needed to do to prepare the workplace for employing the Trainee; clarified what was expected of each team member and of the Trainee; and identified how the Area Health Service management could support the Program:

We ran a workshop with the people who would be the line managers prior to the employment of the Trainees and we worked through the Manual. It gave us an opportunity to really think about it, ask a lot of questions, and answer what we could. (Manager)

Regular meetings for Managers and Supervisors

The Manager Service Development and Performance Mental Health convened a bimonthly teleconference for Managers of Trainees to share information about the Training Program and provide opportunities for discussion about issues arising and strategies for addressing them:

I have a regular teleconference with all the line managers every second month just to try and track how things are going because people get very enthusiastic early and then things slip off the agenda. Also a lot of questions came up in the first six months about HECS, about study leave, about use of cars to go to Uni, all that kind of stuff so we were able to work through them as

a group and make a group decision so that the Trainees were all getting the same information and the same deal.

Regular meeting for Trainees

GSAHS instituted quarterly face-to-face meetings for the Trainees. The Trainees met together with the Manager Service Development and Performance Mental Health for a day to discuss their issues, share information and develop strategies for support. The Manager relayed any issues back to the relevant managers or to CSU for attention. One of the GSAHS Trainees outlined the value of the meetings:

There is a really good support group with the Trainees. And I think it is good that we have that, with issues and stuff that come up. ... This will be the second one this year. If there are concerns with anything that we are not happy with at Uni, we get together and take action on it... For a lot of people, it is hard to voice opinions or concerns. And being of Aboriginal descent, they feel that they are not being listening to... I think, this is a good thing that we are having the meetings... it is good support if there are any concerns there. We can let the people who need to know be aware of them and sort of nip them in the bud before they get out of hand.

Communicating to other managers about the Training Program

The Manager Service Development and Performance Mental Health passed information about the Training Program and issues raised by the managers and Trainees to the Area Health Service management via monthly senior management meetings:

We have a monthly meeting which brings the senior people in my unit and all the cluster managers together where we work through a lot of issues so that's another avenue that I use to raise issues or make people aware of what is happening with the Aboriginal Trainee Program.

Steering groups

North Coast Area Health Service established a steering group to guide the Traineeship. See 'Case Story: NCAHS Preparation and Support for Trainees' in the Workplace Preparation section, earlier in this report, for the detailed description.

Clinical Leader positions

Clinical Leader Aboriginal Mental Health positions were established within a number of Area Health Services to provide dedicated guidance and support to the Trainees and the teams. GWAHS had established three Clinical Leader positions. At the time of the Review, several other Area Health Services were in the process of recruiting to Clinical Leader positions.

Formal site visits

In NSCCAHS, the Area Manager made weekly visits to the Trainee and team to provide assistance, management oversight and academic supervision. The Area Manager described what occurred during these support sessions.

We look at what activities he's done for the week, what he's learnt, what are some of the issues and questions that have arisen. Last week, he was talking about how on some of the home visits he's often left with the consumer and then doesn't really know what to say. So we looked at what are some of the really basic conversational interactions that he might start to engage consumers with... So it really is around what issues have arisen for [the Trainee]. The other thing we have been looking at is some of his university tasks, and some of the preparation and planning that needs to go into these university tasks for him. He'll often ask about some of the organisational processes, just admin type processes that he's not clear about.

State-wide Coordinator position

A State-wide Coordinator Aboriginal Mental Health Workforce position was established in 2006 to oversee the implementation of the Training Program. The Coordinator visited a number of Area Health Services to offer direction for Program implementation and to build relationships. There was a positive response to his visits with comments such as 'very useful' and 'excellent support'.

State-wide Reference Group

As outlined in the Introduction, the Program is overseen by a Reference Group which meets monthly by teleconference. The Reference Group members provided a formal mechanism for communication and direction for mental health services with Trainees.

One Reference Group member responded to a question about the usefulness of the Group:

I think it's been very good. I think it's provided a venue for people to actually talk about the things that aren't working or haven't worked and the things that have worked well and not only talking about those things, it's about solutions as well so it hasn't just been a talkfest, things have been acted upon. I think the other thing is that whole notion, I think no matter how good a program is, if it hasn't got someone driving it and overseeing it, the wheels will get shaky and fall off and they stumble and they stop. So I think even though sometimes it's been quite difficult, this group has like ploughed through and continued...

Mentoring

Both formal and informal arrangements were in place for workplace mentoring by experienced mental health staff. For example, GWAHS had organised formal mentoring arrangements, pairing interested psychiatrists with Trainees and Aboriginal Mental Health Workers.



Aboriginal Mental Health Worker Training Program coordination team with Charles Sturt University Coordinator

One Trainee described how she had organised a mentor outside the health service:

I have got a mentor, you know, I have got a friend who works in mental health and who looks over my assignments and I spend at least two hours with him, on a Thursday night. I have tried not to link any of it in with work, just so that I can talk to him and feel comfortable and we get together outside of the workplace. And we just have a chat about what has happened at work this week and how I am going with Uni and he has a look at my Uni stuff.

Cultural mentors, often Aboriginal people working within the health system or the local AMS, were described as giving additional guidance to Trainees. Aboriginal Mental Health colleagues and other Aboriginal workers, particularly those who had already been through university studies, provided valued advice to Trainee.

A senior Aboriginal Mental Health Worker described what he did as a mentor to a Trainee:

I really got him around and I took him out to clients, sitting in with psychiatrists, coming to team meetings, getting orientated [to the area].

When asked what advice he passed on to the Trainee, he responded:

[You need] to be able to work with both organisations, both cultures, AMSs and Area Health and that's a big challenge for some Aboriginal people because they feel when they're in Area Health they're obligated to fit into the AMSs, and if they're seen too long there [in the AMS]... they [the Area Health Service] might think [the Trainee] is neglecting their protocols and I said, 'No, you're not'. Talk with whoever is having the team meetings and express the Aboriginal views because we are different, we think different, how to treat people. And we know we have to have medication and all that stuff, and tap into the psychiatrists and doctors and nurses and build a good rapport with those places, psychiatric wards, hospitals and all that. So they will get to know you and start to respect you. You've got to make yourself be respected sometimes.

Formal relationships with Aboriginal Medical Services

Where there was an AMS close to where the Trainees were situated, managers had sought to establish formal work experience arrangements for Trainees. The benefits of involving an AMS in the Traineeship included building support, networking and relationship strengthening.

CASE STORY: Justice Health's formal relationship with AMS Western Sydney

Justice Health established a formal relationship with the Aboriginal Medical Service Western Sydney to support the Trainee. The arrangement was initially brokered by the Director Adolescent Health and the Manager Adolescent Mental Health and Drug and Alcohol Programs.

Justice Health approached the AMS Social and Emotional Wellbeing Team to have the Trainee placed there for cultural supervision and to introduce him to the Aboriginal community as a lot of the young people from the local government area go through the court system. The Team Leader was more than happy to take the Trainee on board and agreed to have him attend one day a fortnight. At the six-monthly review, Justice Health requested that his time be increased to one day a week.

Both the Team Leader and Clinical Supervisor acknowledged how well placing the Trainee with the AMS was working:

It's actually been increased now to once a week because they've got a really good service there and there are lots of activities happening. They've got a community mental health nurse, they've got a psychiatrist who goes there regularly and they've got a men's group...

Besides learning about and working with the community, the Trainee was also exposed to a number of AMS workers who encouraged and supported him. When asked what was working well, the Trainee responded:

Working with AMS Western Sydney, I get to spend one day a week there. And that provides me with a very big cultural awareness and also I interact with the community there, so it is really good. The Team Leader is very good; I work with her team. The new Mental Health Worker, he is very good, he is very knowledgeable... He thinks it [the Traineeship] is a great thing. Just more education for our community and the better it is going to be for us, so he actually supports everything that I do.

There was potential for everyone to benefit, as the Team Leader of the Social and Emotional Wellbeing Team pointed out:

When Justice Health approached us to increase his hours here, I felt that I needed to utilise his skills and we've recently received funding for an adolescent mental health worker. So I'm going to utilise the Trainee and his resources to do the foundation work for that program before the adolescent worker is employed. And that's about networking also, linking the new employee into Justice Health to support the young boys. So if he has understanding of the foundation of the new position, then the partnership will run smoother.

When asked, 'Has the relationship between Justice Health and the AMS been strengthened?', the Manager responded, *Without a doubt!*

There was a plan to formalise this arrangement through the development of a Memorandum of Understanding (MOU) between Justice Health and AMS Western Sydney. The MOU would make it clear what was expected from each party.

CASE STORY: Hunter New England Area Health Service and Pius X Aboriginal Medical Service work in partnership to improve services and develop Trainees

HNEAH Mental Health Services and Pius X Aboriginal Medical Service were working in partnership to improve mental health services for Aboriginal people in Moree and worked together to establish a range of processes to develop and support the Trainees based in the two services.

The need for better support for Aboriginal people with mental health problems became apparent to a Pius X staff member when he observed a person known to be a mental health client wandering around the streets. It turned out that the person had not been taking his medication, his family was not really aware of how to support him and he was not receiving any follow-up from the Area Health Service. The staff member could see real benefits for clients if the two Services could work together to provide treatment to Aboriginal people with mental health problems and to help families understand mental health issues.

My job then was to support the clients. And if they wanted me to go in [with them], so that they could understand what the mental health doctor was talking about I had to learn more about mental health. That is when we had to work together...

Pius X began with the employment of a counsellor in 2002 with funds provided by the Commonwealth Bringing Them Home Program. Pius X was also funded by NSW Health for two Aboriginal Mental Health Worker positions (one qualified and one Trainee); however, because of the difficulty finding qualified Aboriginal Mental Health Workers, one position was currently reassigned as a counsellor position.

The Area Health Service supported Pius X to establish its mental health service and continued to provide advice and support to develop its management systems and procedures. The two Services had undertaken a range of joint activities including needs assessment, planning, and review of their joint services and activities.

With regards to joint service planning, Pius and the Area Health are being very conscious of what are the mental health needs of the people in Moree and how best to get that service to them. So you know, that joint planning is very important. We are not only supporting each other through that way, we are supporting our clients and we are getting a better result from them.

The Pius X staff member, now the Mental Health Program Officer, described how the two Services work to encourage community people to attend activities that raised the awareness of mental health issues in the community:

On World Mental Health Day we had a barbeque down here so that we could get our clients, not only our clients, but the Area Health Service clients to come down together... And then we probably only got a couple of them to attend... (So) we looked at why we thought they wouldn't attend, whether [because] it was at Pius. So that was good and was an exercise that we did as a team.

As a result of this joint assessment, planning and follow-up activities, the Program Officer believed that:

The understanding of mental health has picked up in Moree because of the sort of work that we have done and also the sort of work that we are going to be doing. One of the things that we talked to the team about was getting a banner with Pius X mental health unit and the Area Health mental health unit, for any promotions we do outside... So we are seen as a team and not [in competition]... We feel that [we can] get a better result for our clients out of it.

Pius X provided education and advice to Area Health Service staff on how to work more effectively with Aboriginal clients and the local community, and supported Area Health Service activities by providing follow-up with families and communities. The AMS had outreach workers based in nearby communities that could provide ongoing support after health professionals' visits. The Pius X Program Officer provided input to Area Health Service staff selection processes, through provision of advice and by sitting on selection panels.

The Moree Mental Health Service and Pius X were working in partnership to train and supervise the Trainees based in each of the services. As part of their Service Level Agreement, the Area Health Service developed a work plan for the AMS Trainee and provided supervision. The Traineeships were jointly managed by the Area Health Service Community Mental Health Manager and Pius X Mental Health Program Officer who undertook joint staff appraisal.

A senior clinician from the mental health service took the role of supervisor and preceptor for both Trainees. The Trainees were working as a team. The senior clinician was undertaking a clinical leadership course and working with the Trainees in supporting her professional learning.

The Pius X Program Officer described the value of the partnership for both Services:

Because we are only a new unit, we really do need that support from the Area Health to keep going and to keep us on track... The Area Health Service manager feels that she can get value out of us, too, and vice versa, we can get value out of them. I didn't think it would work with the Area Health. I thought they would come in and they would say, 'You do it this way'... But with [the Area Health Service Manager] it was different and she really understood what we were doing and what we needed to go through and that is why I feel that it is working between us. Area Health is not just the big brother coming in, you know, looking [us] over. They have given us the respect that we needed to go on; because I know some places you don't get that sort of respect that we can do it. And they have given us that confidence that we can run a mental health team with that support that they are giving us. So that is why I feel that we are going somewhere and that things are working.

INFORMAL SUPPORT STRUCTURES

Trainees initiated ways to ensure support for themselves. Many of the Trainees found ways to link up with other Aboriginal workers in the Department of Health or in other departments or organisations. Support activities included regular email contact and occasional visits.

I have got a close family friend that I grew up with, we are sort of on the same train of thought when it comes to certain things. He actually supports everything that I do. He is a Mental Health Worker, so it is really good to be able to sit down and talk; he and I treat each other like kinship brothers, so that is really good. (Trainee)

Trainees established contact with other Trainees to discuss university assignments and work issues. Trainees also utilised the assistance offered by Aboriginal Mental Health Workers who were in higher years of the Djirruwang Program or who had graduated.

Family, friends and community members also provided significant support and encouragement for Trainees:

If I didn't have such strong support out of work from my pastor and my friends, I don't think I would have made it because I found I was burnt out at the end. (Trainee)

Managers provided informal support by being accessible and available for Trainees. As one Manager explained:

... We've developed, with the Aboriginal Mental Health Unit, with myself, lots of informal channels and we've made it really clear to him, 'All you need to do is make a phone call. You don't need to book a time to see me. You don't need to go through all these formal channels, just ring me up'. And we've made that clear. So we have those formal processes, but we have lots of informal processes that we use all the time.

CHALLENGES PROVIDING TRAINING AND SUPPORT

Teams' capacity to train, supervise and support a Trainee

To provide effective training and supervision takes a considerable amount of time and a real commitment on the part of the mental health team. Some team members reported that they did not appreciate how much time was involved in providing on-the-job training. Time spent with a Trainee may reduce the number of clients the clinician can see in a day. Small teams experienced added time pressures, and many grappled with how to combine their caseload requirements with the need to provide a high level of on-the-job training.

I think that's one thing that is really clear is that you need dedicated time and money to fund the proper supervision. Loading it onto people that are already busy, it's very hard and doesn't work really that well. I mean it does work, but it's an impost that makes the experience much less valuable, I think, and puts added stress on the staff. (Director)

When asked what she needed to help her better support the Trainee, a Preceptor suggested:

Having more time, someone to pick up half of my caseload would be nice so I could spend more time with [the Trainee] but ideally it would be nice to have that time to do more small tutorials with him, basic information, you know, start at the beginning, with the basic concepts of mental illness. To have the luxury of having that time because I feel quite negligent at times and I think I really would like to be able to keep him occupied and sit down and do this stuff, but I just don't have the time.

Only one team reported that they recorded time spent in training and support activities in the Mental Health Outcomes and Assessment Tools. This type of data is necessary to account for the actual time cost of the Training Program.

In a small number of cases, Trainees were placed in teams that were too small to provide adequate support and, in one case, the mental health team disappeared around Trainee. In some circumstances, Trainees were placed in teams where the arrangements turned out to be unsuitable for either the Trainee or the team. In one case, a Trainee was moved four times until a suitable and willing team was found. Placing a Trainee in an in-patient unit was found to be particularly challenging for both the Trainee and the team.

I think the biggest problem was having a Trainee in an acute setting, where everything was just go, go, go, you know. People work here 24 hours a day.

So people were just on the go all the time and no one really had time to sit down and explain to me... I was brand new to the mental health system and I did need some kind of guidance and support... (Trainee)

Careful management by the line and area managers averted potentially destructive consequences for Trainees in these situations.

Cultural considerations

A number of Trainees were working in workplaces with no or few other Aboriginal workers and expressed feeling culturally isolated.

Probably the most challenging thing for me is just working in an Indigenous role with a lot of non-Indigenous people around me. (Trainee)

Trainees had varied experiences with and knowledge of the local Aboriginal community. Although some Trainees belonged to the local community, others had come from other communities or regions and had to work at getting to know local Aboriginal people and cultural protocols.

A number of interviewees emphasised that it was important to understand the pressures on Trainees who were working to overcome the stigma mental illness has in Aboriginal communities; the fear people have of being caught up in a 'culturally insensitive' mental health service; and in some places, a history of poor service delivery to Aboriginal people.

A Trainee described how difficult it was for her to encourage people to access mental health services:

If I say I work with mental health, some people won't see me anymore... [I try to explain] to people not to be ashamed to access mental health, you know, the services that go down there [to the community].

Managing community, family and workplace expectations

Trainees can come under pressure from their communities, family members, health staff and team members to undertake work that they are not yet qualified or authorised to do. They can also be expected to perform certain tasks or to know certain things because they are Aboriginal. There may be cultural reasons why they are not able to meet these expectations. Some Trainees nominated managing these expectations as challenging or the most challenging aspects of the Traineeship. The following quotes illustrate how these expectations were expressed both by team members and Trainees, and how they were managed.

Community expectations

And the curry they [the Trainees] are getting from their own community, 'Why aren't you working with us anymore?' So they have had to rebut that quite a lot, and I spoke to the Senior Aboriginal Mental Health Worker about that and I think she went and spoke to some people about that as well. Some of the Elders and so on, but that was quite a pressure, coming from their own people, all year. (Education Officer)

Family expectations

[The most challenging aspect is] seeing family members and what they expect of you. They don't really understand about policy and procedure when they are unwell. I just tell them because they are family members, I can't work with them and they usually get a bit snotty and say, 'You are just selling me out,' and you know, 'Why?'.

When I sort of had to work with them and it was very hard. So it is not going to happen again... Like if my brother ever came in here, there is no way in the world. Or if my mother or father, I wouldn't work with my aunty. I have made boundaries. So I will say to [Preceptor], 'This one here is a cousin, so I can't deal with him'. So he will handle it for me. (Trainee)

Workplace expectations

... But the expectations are going to be very high, that's why we've got a lot invested in making this work with [Trainee] and I take him into the in-patient unit and you know, they're very interested in what he's doing from a community point of view. I'd introduced him as the Aboriginal Mental Health Trainee and then we'd get phone calls to find out, 'Can we refer to him?' and I'd have to say, 'No, I'm sorry but that's not possible'. So there's a lot of interest and a lot of hopes pinned on this position working out. (Preceptor)

I was asked to do a 'welcome to country' a few weeks ago. [The Manager] asked me to do one, but I'm not from here. I didn't want to do it and he was like pressuring me to do it, but I said 'No'. He said how come non-Aboriginal people do it and I said, 'I think they just do an acknowledgement'. I think he was a little bit disappointed. Usually the Elders do it from the area. (Trainee)

I have been asked a couple of simple questions [about Aboriginal culture] where I just can't answer them, you know. I think it would be just like working with somebody who is French and asking them about their culture and expecting them to know everything about their history and stuff... I think the expectations are probably a little bit too high of non-Indigenous people around you, to know a lot. (Trainee)

Several Trainees suggested that workplaces would benefit from being exposed to more cultural awareness programs. Trainees (and other Aboriginal Mental Health Workers) would appreciate an understanding of the kind of pressures Aboriginal workers are under when trying to be conscientious health service employees and members of their community. One senior manager has ordered the *Indigenous Times* and *Koori Mail* for the Trainee and team as one way of raising cultural awareness.

A senior manager described a conversation he once had with an Aboriginal Worker:

But also I've seen tension between what the Aboriginal community expects of the worker and what the health service expects, and I can clearly remember a lady who was a great worker telling me, 'If I drive, if I've got the health service car and there's a couple of ladies walking up the road with their groceries or something and I drive past, the community will shun me. I know I shouldn't pull over and pick them up; it's one of the health service rules and regulations but, hey, I'm trying to get the community to access [the service]'. So there's that conflict, if you like often, for the worker.

Confusion caused by inadequate understanding of the Training Program

The level of support for the Trainee was influenced by the level of knowledge about the Training Program as a wider initiative. Services that did not receive an adequate briefing on the Program's objectives and the structures and resources available to support it experienced unnecessary confusion.

Teams that had not received adequate information prior to the recruitment process recruited Trainees to different position descriptions. They did not understand the requirements of the Traineeship regarding the relationship between work and study, the limits of a Trainee's ability to have a caseload, and entitlements and expectations regarding study and supervision. See the earlier section 'Workplace Preparation'.

The Manager in an Area Health Service that originally recruited Trainees as Liaison Officers described the confusion and angst caused by later turning the positions into Trainees (but not changing the job descriptions):

Because I wasn't aware of them being Trainee positions, we were actually looking for someone who had some level of qualification of some type. This was a challenge for the [successful applicants]... [one Trainee] has very much struggled with the concept of having to do the study as well. I don't think she was fully prepared for what that meant.

But that's [lack of knowledge of the Program] been a challenge in itself and I guess from our experience those would be the sorts of things that we would be feeding back to anyone embarking on that process. Make sure you've got your basics first, in terms of people that can actually drive the process and then obviously the systems that go around that infrastructure in terms of documentation and stuff, and then recruit. But hindsight is a beautiful thing. We will know for the future.

An inadequate understanding of the Program by managers and teams meant that Trainees often had to set their own boundaries related to work requirements. Failure to set clear boundaries may expose Trainees to criticism for practising beyond their scope or to a culturally unsafe working environment.

Yep and that comes down to that gatekeeping stuff... even though the managers have got the Manual there and they know what we're supposed to and what we're not supposed to do, they're not reading the Manual. You come across as somebody that knows your community and you know what you're doing out there, you might look [experienced] but you haven't got the piece of paper to back you up and you always have to be a gatekeeper. Your own gatekeeper and saying 'I'm not qualified to do this, I don't deal with psychosis; yes, I'll help you transport or no I can't do an assessment or a home visit on my own because I'm not allowed to'. (Trainee)

CASE STORY: A challenging beginning in GWAHS

Initially there was some confusion about the Traineeship and the Trainee's role. It was soon rectified and the Team enthusiastically incorporated the training and support of the Trainee into their work pattern.

A Trainee position was placed at Bloomfield Hospital, an area of need identified by the GWAHS mental health executive. The Acting Director of Clinical Services decided to locate the Trainee with the Social Work Team, reasoning that the role an Aboriginal Mental Health Worker could take up within a mental health hospital setting would be most closely aligned with the welfare, counselling, and community development role and the holistic approach of social work.

The Senior Social Worker reported that the Team was delighted to have an Aboriginal Mental Health Worker position located with them. It was only after some weeks that they appreciated the position was a Trainee position. She explained that had she known about the Training Program, she would have managed the Trainee's first weeks with the Team differently:

The first two weeks could have been the orientation, observation and touring around different wards and giving a clear picture to all others involved as to what the Trainee's role in the different wards would be. We had to go back and tell the staff in the different wards what could be expected of a Trainee.

The Trainee became aware that the Social Work Team did not have an understanding of his role, and had a suggestion for how the process could have been improved:

Because of the orientation process, it wasn't given to staff. They didn't really get a good heads up from the Uni or anyone like that. There are so many different roles around, and I think a lot of people actually thought I was here to provide a service.

I think the university or whoever could have spoken to the managers and the whole Social Work Team, and just given them a few pointers around the aim of the Program. What is the aim of the Trainee [Program] and the requirements of the Trainee? The Social Work Team apologises and it is not their spot to apologise.

Despite the challenging start of the year, the Trainee reported that being with the Social Work Team was working well for him. He was being exposed to the whole range of mental health professions and was beginning to gain practical experience:

I am doing things like case reviews, admissions. I take part in case reviews but I just observe admissions, because it's the doctor's duty. We do drug and alcohol groups, we do art groups, yoga groups. I observe in a lot of those, but I do lead cooking groups and tennis groups, like basic things. But psychology groups, I just observe. It is good stuff.

The Occupational Therapists and Diversional Therapists have taken me under their wings, as I will be running Indigenous specific groups, and I have just been with those guys to pick up skills... There are five main disciplines in mental health and I am trying to get around to all those disciplines.



Aboriginal Mental Health Trainee and colleagues in Greater Western Area Health Service

OVERCOMING THE CHALLENGES

Teams overcame their limited capacity to train and support Trainees and to extend their workplace experiences in a number of ways, including:

- Negotiating for the Trainee to be placed with a different team for three months to experience a different mental health care service.
- Negotiating a different arrangement with regard to a 'home team' and a 'placement team'.
- Moving the Trainee to a different service.
- Moving the Trainee to a more supportive team.
- Arranging placements in ACCHSs, or in other types of services to increase the Trainee's range of experience.
- Making arrangements to ensure the Trainee was supported from a distance.

To overcome the major challenges of staff shortages and time pressures with the need to provide on-the-job training and support for the Trainee, team leaders and supervisors came up with a number of strategies, including:

- Encouraging all team members to become involved in training.
- Setting tasks for the Trainee to complete and report on.
- Allowing Trainees to work on university assignments in the workplace in addition to their allocated study day.

Trainees overcame support difficulties themselves by setting up peer support avenues, speaking up for themselves and taking the initiative to arrange their own professional support from a distance.

[I] learnt to use the phone and get on the phone and talk to people I guess, like for instance the other day I rang one of the workers in [nearby town], I just needed to know something and there was nobody around so I rang her, things like that. I'm not shy anymore, like I'll ring the psychiatrist in [regional centre], we've got his number so, yeah, basically pick up the phone and talk. (Trainee)

Reviewers identified that having at least one person who took responsibility for the Trainee and served as a constant point of contact was important in creating some stability for the Trainee, especially given the level of staff turnover and high workloads.

In order to overcome cultural isolation, it was suggested that there be more cultural awareness training for team members, more discussion within the team about how to work most effectively in the local community and more effective linking of Trainees with cultural mentors.

CASE STORY: NSCCAHS overcoming challenges

Despite a number of challenges faced by the NSCCAHS, including a high turnover of staff, difficult placements, lack of Aboriginal health staff and lack of role clarity, staff reported positive outcomes from the Traineeship and outlined plans for the future.

The NSCC Trainee is an Area position, with the Area Mental Health Clinical Partnerships Coordinator responsible for overseeing the position and the Manager of Community Development and Partnerships Central Coast directly line managing the Trainee. There are few Aboriginal Mental Health Workers in NSCCAHS although there is a significant and growing Aboriginal population on the Central Coast and a number of Aboriginal organisations providing various services. The Trainee was originally co-located with an experienced Aboriginal Mental Health Worker in a hospital setting. The Coordinator explained her reason for placing the position where she did:

The Central Coast Service was telling me that there was this really unique collaboration with Aboriginal workers on the Central Coast and that this would be a great opportunity for the Trainee to be a part of that, and that Aboriginal Mental Health Worker was placed in this collaboration. He later identified that the collaboration didn't work all that effectively, that he felt quite isolated from the mental health services, that the local community was unclear about his role because he sat with drug and alcohol workers, so you know, theoretically the collaboration was probably a great idea but I'm not sure practically that it was ever going to be able to support the needs of the mental health workers and the Trainee.

The Aboriginal Mental Health Worker reported how important it was to have the Trainee located with him:

My highlight was getting the Trainee on board here and having the Coordinator and Manager, they were very supportive... They put him with another experienced person which was myself which was very vital.

He was only with me for about four or five months. I really got him around and I took him out to clients, sitting in with psychiatrists, coming to team meetings, getting orientated... and the other Aboriginal organisations that were all scattered around the Central Coast, there's not a real lot of them but when we were there they were happy to have us on board and we were pleased that they were there.

So my highlight was having the Trainee on board and especially putting him back down through Djirruwang...

The Aboriginal Mental Health Worker played, and would continue to play, an important mentoring and support role for the Trainee. He offered reassurance and guidance:

So the challenges are only just I guess it's relationships, I reckon, and who you are and your role, your job description and being Aboriginal. And he's up there with all those non-Aboriginal people.

Except for the Coordinator, all the staff who had originally been involved with the Trainee took up positions elsewhere. The Trainee had four different line managers in his first year and was placed with four different teams. At the time of the interview he was currently placed with a multidisciplinary, community mental health team and was learning about how the service worked.

The Trainee reported that he was getting good support:

I go out weekly or fortnightly when they do injections, going on home visits and outings with the clients and a few more meetings... every day, they have a review of their clients in the morning. I got used to it; in the first week I didn't know what the board was all about but then I got used to the structure. It actually is a good way they do things; it's all like organised. Sometimes I ask some questions if I'm not familiar with something and they explain it to me. Yeah, it's really good here, a lot of support.

The Coordinator continued to support the Trainee and the Manager and, in fact, had been the constant person in the Trainee's career so far, beginning with being on the interview panel. After the Aboriginal Mental Health Worker left, she started spending one day a week on the Central Coast. A few hours each week were spent with the Trainee, providing support, going over what he had learned, helping with assignments, sorting out issues, answering questions.

Although the work situation was more stable, there were ongoing challenges for the Coordinator:

The distance, you know to be able to be reassured that it's working well. I think you need to be physically closer and for me to be able to offer the Trainee more regular contact, to be confident that the systems in place are working and operating as well as they could.

So what was the highlight over the last year for the Coordinator?

The highlight has been seeing the Trainee's development. You know you can see quite marked changes with him over the 12 months and he really values the position and the role.

COMBINING WORK AND STUDY

Balancing learning a new job with undertaking tertiary study presented Trainees with some of their most challenging times in the first year of the Traineeship. In addition, some Trainees had significant family commitments to fulfil. Circumstances and strategies that made it possible for Trainees to more easily manage the on-the-job training and study combination included: being in teams supportive of professional development; having allocated time in the workplace to complete assignments; undertaking placement requirements within commuting distance of home; and operating within clearly demarcated boundaries.

- Undertaking placements in the same geographic area in different health services, programs and local AMSs contributed to building an understanding of the Training Program and strengthening links between services. It also decreased the Trainees' stress by not having to be away from family and support people.
- Having realistic expectations about what can be reasonably expected of a Trainee at each stage of Traineeship was viewed as very useful by both Trainees and teams where they were applied.

SUMMARY OF SOUND PRACTICE IN COMBINING WORK AND STUDY

- Having a preceptor, supervisor and team members who were available to discuss assignments directly assisted the Trainee in completing them and increased the knowledge about the university component of the Traineeship.
- The more managers, clinical supervisors and preceptors knew about the university's expectations the better they were able to support the Trainee.
- Having an allocated study day during the week between residential teaching blocks and resources such as a laptop computer enabled Trainees to more easily complete university requirements.
- Trainees who were able to organise a tutor reported that it had helped them with their time management and ability to understand and complete their assignments.

A learning environment

Team support

A team that supports the Trainee's professional development has a number of characteristics conducive to the creation of a 'learning environment'. These include a team leader who values training and study and a team that is willing and enthusiastic about being involved in a Trainee's learning.

We made it quite clear that nothing was to interfere with their studies and that was the most important aspect of it. Don't get caught up with going out and seeing everybody, get that core knowledge. (Manager)

I think what's working for me is that we have our Preceptors. They are so important. Being able to go to them, chat with them, even about our Uni studies. I think another thing that's important is that we have our study day every Friday so that helps us get things we need to get done for Uni. (Trainee)

Being able to work in a multidisciplinary team—psychiatrists, doctors, clinical nurse consultants, all those sort of people—has helped me out and having the support behind me, when it comes to needing a hand with Uni and stuff. If I go to

anyone with a problem from Uni, it is usually 10 people jumping at me to help me. (Trainee)

Actually, I think I'm really lucky; the whole experience has been fantastic... I just think it all works well, I'm not sure exactly what works, but I just think it's a combination of things, and you know, the people that I work with, they're willing to pass on knowledge and they don't get jack of me asking questions and they're supportive. (Trainee)

In teams that hosted students regularly, there was a greater understanding of the level of support required for Trainees; in teams where a number of staff were studying, an environment supportive of study and learning was created.

I did find it a bit stressful when I first started, but I got a lot of support from people here, because a lot of the other people here are also studying, so you know, there is probably about 50 that are employed here, that still do study. (Trainee)

The caveat is that if a service hosts too many students, Trainees feel that they either need to step aside or feel pushed aside.

Knowing about the Djirruwang Program

The more managers, clinical supervisors and preceptors knew about the course expectations the better they were able to support the Trainee. Some interviewees reported that they would discuss the course topics that Trainees were studying or were particularly interested in. One clinical supervisor described how she conducted some of her sessions with the Trainee:

I talked with him about drug and alcohol this year to introduce him to perhaps different ways of thinking about drug and alcohol. I did the same with domestic violence. So it's more like we'd have little debates about issues and I'd present my viewpoint and then he'd present his. It was that adult learning stuff. And we did that with a lot of issues; there were particular things

that might spark his interest, so he'd get back to me and say he'd read something in the library or there were some social issues around, like watching DVDs such as 'Beneath Clouds'...

It was very useful for managers and coworkers to know what the Trainees were doing each semester.

They've looked at what next year's subjects are and my team leader's said he's going to link me in with some of the services next year so that my competencies are met. (Trainee)

Overall, team members expressed frustration at not being able to do more to support the Trainees in their study because of a lack of understanding of the Djirruwang Program curriculum and course requirements. There was confusion especially around placement learning objectives, workplace learning objectives, how competencies are met and assessed, and how it all links with the Djirruwang Program curriculum.

Experienced clinical supervisors described their experiences supervising students on placement with them from other courses. One provided the following description of the process in place for social work students:

Before the student comes, I've actually got a person to talk to from the university. [The placement] is so many hours, they need to cover this. It is all very verbal and very brief on the phone or on the email. Before the student comes, a package comes to me with a disk as to what the university's expectations are, what to do, what not to do. It is my guide: it has got the learning plan, learning outcome, how do they demonstrate they have satisfied what is in the learning plan, all of that. There is a signed contract, all of that's been done.

She explained how the student on placement was followed up:

They're called field teachers... they come and do the review with the student. If they're unable to come, they do it by phone... My concern is the



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link with the university. I'd really like to have one person as a contact when I have questions to ask. When I need clarification, there should be a central person for me to talk to.

This Preceptor was going to great lengths to adapt other social work course placement documentation to make it applicable to the Djirruwang Program. It was her way of providing more structure for herself, other team members and the Trainee in order to guide him and to be able to assess workplace learning outcomes.

Allocated study time and resources

Trainees reported that having an allocated day during the week for study was essential for them to be able to complete assignments and to achieve some kind of balance with their home life.

I do find it a bit hard to balance, but luckily enough, I have got that one day a week where I have got a study day. I never seem to get behind in my Uni work, because of that one day... I would probably be up till 11.00 or 12.00 at night each night, trying to get stuff done, if I didn't have it. (Trainee)

Well initially, I wasn't getting a day off for study but that came in at the end. That helped a lot. I went up to the Uni, did some research and study,

and that was good. Most beneficial was just having the time to do it, being awake, you know, getting a full night's sleep, then getting up and doing it. Not going home after a big day and collapsing at the computer. (Trainee)

Trainees also explained that having some flexibility to work on assignments at other times was important in being able to meet deadlines.

If I feel like I am falling behind, I will ask [Manager] for a study day. Sometimes I just ask for an afternoon when it is pretty quiet, because [Manager] said I could do it if I needed to finish assignments... (Trainee)

Having resources available such as laptop computers were reported to make it possible to work on assignments in the evenings, on weekends and at the residential teaching blocks.

Not having a laptop computer, for example, caused problems for some Trainees:

I have got a bit of a complaint about that actually, because Trainees actually get laptops and they can take them home and take them to Uni. I haven't received one yet. So it makes study time, very, very hard at home, because I don't have a PC at home. I need a laptop. Trainees are meant to get laptops, because of the mobility, so that we can take it home and do assignments.

Trainees are eligible for two hours per week of specific content tutoring for each (16-week) subject. The Department of Education, Science and Training funds the tutoring through the Aboriginal Tutorial Assistance Scheme. The tutoring is approved and organised through the University.²¹

Those Trainees who were able to organise a tutor stated that having a tutor was very helpful.

Having a tutor just towards the end there [was helpful]. I was just starting to get a bit overwhelmed. The tutor sorted through a few things, put me back on the right track. (Trainee)

From previous study, when I did my diploma, I understood the importance of having a tutor. I took that on myself to go and source one. I had a friend who was working in mental health, and I rang and approached her and said, 'I need a tutor, do you have anyone in mind?' And she just sort of flicked an email around to all the people in Aboriginal mental health and I was lucky, [a person] put her hand up and said that she would like to be involved. (Trainee)

Local placements

Undertaking placements in other services, programs and AMSs is a University requirement.²² Ideally Trainees undertake a placement corresponding to the clinical placement subject in each semester. The purpose of the work experience is to gain practical knowledge and skills in the subject area. For example, in Year One semester two, Substance Abuse is a clinical placement subject and Trainees were expected to spend two weeks in a Drug and Alcohol Service.

Trainees who had undertaken their placements in a local service reported several positive benefits, such as meeting other service providers, gaining an understanding of the services available to the community, and learning about the practical issues:

I went to the Methadone Clinic, saw the court system where people have been referred from court to hook up to the service for drug and alcohol, the MERIT Program. They have 24 hours to go and do it... Went to an isolated area, a community with one of the workers who works up there, saw what he does for a day and he just let me know all the agencies he interrelates with so you know what services go up there and helps him out in that community... Oh, I met all the other side of the building which is community health service over there, all the community health workers. I met all the different sexual health workers, worked with the drug and alcohol person, and the podiatrist. I hadn't been across to that side of the building before. It just opened my eyes, being in that field... and being in the interviews at the Methadone Clinic. There were only one or two Aboriginal clients that came in but most were Non Indigenous, you know what I mean, so it certainly opened my eyes up... (Trainee)

Travel away from home for an additional eight weeks a year to complete placements put additional pressure on Trainees, especially those with family responsibilities. The University did not have a clear policy or set of criteria with regard to acceptable placements. This resulted in some Trainees being allowed to undertake placements in local services and other Trainees' requests being refused. Some Trainees reported that it was very difficult to organise the additional time away from their families:

²¹ Watson, C and Harrison, N (2006). *Aboriginal Mental Health Worker Training Program Manual*, CRCAH, Darwin, page 44.

²² In Year One, Trainees attended University for eight weeks and undertook four weeks of placements. In Years Two and Three, Trainees attended University for eight weeks and undertook eight weeks of placements.



Trainees and colleagues enjoying the evening at the NSW Aboriginal Mental Health Workers Forum, Sydney

I think [what has not worked well] is the absence from home. [The Course Coordinator] prefers us to do our clinical placements not in our own environment but to go and experience other services. But, that's not always practical with a lot of the young mums. I mean 16 weeks a year is a long time away from family. I have lots of family responsibilities. It's not an option for me to be away. It's hard enough going to university for the eight weeks a year. It's almost nine... (Trainee)

Realistic expectations

Trainees who operated within a workplace that had realistic expectations about their capabilities at any given stage of the Traineeship expressed satisfaction with being able to meet their work and study demands.

They also were able to understand and explain to their community and family members what they could and could not do at this stage of their Traineeship:

And that's, I guess, what was appealing to me was that I could do something, learn something. I didn't have the responsibility of case managing clients. It was just perfect for me, and right now, after a period of time, I do have contact with clients but that's always where there's another worker involved. I get the opportunity to take intakes, but that's only after checking with other workers and whatever first. The whole process has been really good. I think I've been here for about eight months now, and that's just been sort of a gradual process. So initially, and even now, I can't have contact with clients unless there's another worker there. (Trainee)



Landscape of southern NSW

Combining work and study: an attractive option

Several Trainees reported that they were attracted to the position of Aboriginal Mental Health Worker Trainee because it offered workplace training combined with obtaining a tertiary qualification. *Yes, it was just perfect for me and I thought it was meant to be for me.*

These Trainees talked about how they had been looking for new challenges when they saw the position advertised. The timing was ideal for them.

Being able to be employed full time, with a full-time wage and being able to study for a degree, which is what I have always wanted to do—study for a degree. So this is going to give me a great opportunity to do that. (Male Trainee)

It suits me perfectly. If it was a full-on type job, I might not have applied, but that was part of the appeal, that you do learn, you get to study and learn the job thoroughly before you take on full responsibility. And I just think, yeah, the whole deal is just fantastic, and you know, with the studying and the other training I can access, that's been really good, and I can fit in with full-time employment, it just works really well. (Female Trainee)

I feel that if you are going to perform at any job or you know, be competent in any job, you have to have prior knowledge and an understanding... And I think if you are working

and you are doing study at the same time, you are putting your theory into practice... It was perfect. It was what I had been looking for a long time. I wish they had something like this when I left school. (Male Trainee)

Combining work and study was not without its challenges. One Trainee described it as 'a balancing act':

Challenges: I guess if you are married with kids, it is a bit of a challenge, just balancing you know, family life with work and study, all together.

Others talked about the difficulty of actually studying and doing assignments:

I'd have to maybe say the study... it's just, oh, I'm not that fond of it really, but I knew like when I applied for the job that that's the part of the deal that you've got to do, it's a Uni course involved, and so I accept that. But I'm just not particularly wrapped in it, that's all. That would be the biggest challenge, I suppose, doing my assignments.

I'm a more hands-on person, so most of it makes more sense to me learning on the job. But there's no doubt what I am learning at Uni, it you know, works in with work, and it all makes sense. But I'm a better hands-on, visual sort of—I take things in better that way.

CHALLENGES COMBINING WORK AND STUDY

Managing caseloads and study

As the Trainees progress in the Traineeship, their caseload commitments will grow and they will need to develop strategies to manage caseloads and study. The University did not make allowances for employment requirements. Some Trainees related being stressed by these competing demands:

It just feels that because we're Trainees we're expected to have everything done and if we don't do it we're going to get fronted by our workplace which has that stress of if we don't do this, my workplace is going to get up me; but if I don't do this, Uni is going to yell at me; and if I get behind in this, I could lose my job; if I lose my job well there it all goes'. Like you've got two little kids and all that... (Trainee)

Line managers and supervisors expressed the need for timely communication from the University about Trainee progress. If Trainees were experiencing difficulties meeting University requirements, the workplace wanted to know as soon as possible so steps could be taken to remedy the situation. Area Health Services have an enormous investment in Trainees successfully completing the Degree.

Balancing work, study, family and commitments

A number of Trainees spoke about being mentally exhausted at the end of every day as a result of combining work and study. Trainees explained the sorts of pressures that they were under trying to balance all the factors in their lives. Some Trainees had taken a pay

cut to take on the Traineeship, putting them under financial stress; some had heavy family commitments to attend to, and some found it difficult not to be available to honour those commitments.

Well I'm a sole provider at my house and I'm in the juggle thing with the kids and it's just like being a sole parent and it's a bloody nightmare. (Trainee)

But I was there trying to get my assignments done you know, like everybody else and we had a death in the family while we were away, like one of our cousins had passed away, and that was really hard for us hearing that while we were at Uni, so I guess there's lots of things people need to understand as well. (Trainee)

University program

During the interviews a wide range of issues were raised about the Djirruwang Program and how it was being implemented by CSU. The Reviewers did not examine the University Program or interview any of its staff. Three evaluations were conducted between 1996 and 2006 that made recommendations for further development of the Program and improvements in implementation.²³

As a result of feedback received from this Review, the Mental Health and Drug & Alcohol Office in NSW Health wrote a letter to CSU asking for a meeting to discuss concerns about the Program. A meeting was held between representatives of NSW Health and CSU in February 2008. It was agreed that a Memorandum of Understanding should be entered into between NSW Health and CSU to address concerns about the Program and the NSW Health Trainees. A Memorandum of Understanding was in the process of being drafted.²⁴

²³ See Introduction for reference to the Djirruwang Program Evaluations.

²⁴ The MOU was signed on 3 February 2009.

HIGHLIGHTS OF THE TRAINING PROGRAM

Interviewees were asked, 'What have been the highlights of the Training Program for you?'

Highlights for Trainees

- Getting the Traineeship initially.
- Being able to combine work and study.
- Working in mainstream.
- Being the first Trainee in the area.
- Completing the first year successfully.
- Going to university to get a degree of which to be proud.
- Learning at university and getting to know about mental health services.
- Learning different things every day at work.
- Applying what was learned at university to client care.
- Being able to help the community and to advocate for the community.
- Seeing the benefits of what mental health services can do for people who are unwell.
- Learning about medications and their side effects so can explain them to Aboriginal clients.
- Being acknowledged as a valuable member of the team and affirmed as having 'specialist' knowledge about Aboriginal culture.
- Knowing clients have learned something about how to change as a result of a counselling session.

- Meeting other Trainees at university who are all willing to finish and do well for the community.
- Knowing that the Traineeship is a 'stepping stone' to further professional development and work opportunities.
- Learning about one's self and one's abilities.
- Using the new knowledge about mental health as a building block for one's own personal wellbeing and the family's wellbeing.

Highlights for Mental Health Staff

- Having Trainees 'on board' who are enthusiastic, capable, accountable and who want to work and study for a degree.
- Having Trainees 'on board' who have a commitment to work with the local Aboriginal community.
- Observing how well the Trainees are supported by mental health teams and by the Aboriginal community and organisations.
- Enhancing and extending the multidisciplinary team approach by having Trainees as team members.
- Realising that the Trainee is bringing the team together and providing a focus.
- Knowing that Aboriginal clients and the community are going to get a better service.
- Observing how the Trainees are role models for their families and communities.
- Watching and participating in the Trainee's professional and personal development over the year.

- Seeing Trainees 'stand tall' after a year in the Program.
- Observing the Trainee becoming more confident and comfortable in the role over the year.
- Hearing the Trainee use the language of mental health confidently and correctly.
- Watching the Trainee build relationships with other service providers.
- Linking with the local Aboriginal community through the Trainees.
- Learning about the lives of Aboriginal people and about their community.
- Having the Trainee successfully complete of his/her first year of study.
- Learning about the State-wide nature of the Training Program.
- Seeing Aboriginal Mental Health back on the agenda.
- Being part of a vision for improving Aboriginal Mental Health.

BENEFITS OF THE TRAINING PROGRAM

It became obvious during the course of the Review that there were significant benefits attributed to the Training Program. Although Reviewers did not ask an explicit question about the benefits, Program participants spoke about or alluded to what Reviewers interpreted as benefits. Sample quotes have been included to illustrate these benefits.

Benefits for Trainees

- The Training Program provides the means for contributing in a meaningful way to improving the health of the local Aboriginal community.

... Maybe I can help them in the mental health area and it's been a passion of mine for a long time, [but] I didn't want to do anything without the training. I felt that I would be doing a disservice to my people and I didn't want to do that so when this [Traineeship] came about and I saw the training involved with it, I thought, yes, this is what I've been waiting for.

- It provides the opportunity for personal development. Trainees related how they learned about themselves and their abilities, and changed positively as a result of participating in the Program.

I think it's a stepping stone and a building block to my own personal wellbeing and also to my family wellbeing. I've learnt a lot about myself; I've learnt a lot about mental health; I've learnt a lot about lots of stuff; but I think if anything, I probably learnt more about myself and my own ability.

- It combines paid employment with paid support for a university degree. Upon completion of the degree and satisfactory performance in the workplace, a permanent position is assured. It is highly valued by the Trainees.

Being able to be employed full time, with a full-time wage and being able to study a degree, which is what I have always wanted to do, was study a degree. So this is going to give me a great opportunity to do that.

- It is a stepping stone to further professional development. Already some Trainees are thinking about the professional pathway they want to travel.

It's a good stepping stone to be able to go to any other area you want to do. You can pretty much branch off to wherever, whenever, once you've finished your Traineeship.

Benefits for Mental Health Services

- Trainees bring to the mental health teams their knowledge of the issues facing Aboriginal individuals, families and communities and the most effective ways to communicate and respond.

One of the good things, too, is [the Trainee] being part of the Aboriginal community locally. When I was going around with him, it became evident to me that it was going to be much easier to make contact with Aboriginal clients and that he knew just a hell of a lot more about what was going on in the community, knew who people were and so on. You know, really a great amount of information that the Trainee's got or the exposure he's got to these people is complementary to what we know about the treatment and when you're trying to track them down or trying to find out what you can about the history or personal connections... it's been extremely useful; it's worked extremely well. (Team Member)

- Trainees can contribute to increasing teams' knowledge about contemporary mental health issues through presentations prepared for university assignments and feedback from conferences.

When you get into depth about the Stolen Generation and how it impacts on their life, and you see older guys from the Stolen Generation coming in here, it is real life stuff and then you can relate to that person, because you have learnt it at university... Probably when I have a bit more knowledge [I will present to the team]. (Trainee)

- Having a Trainee can facilitate team cohesiveness and balance.

I think it makes the team more cohesive. Teams can lose their way a bit and get a bit overconfident, and they can tend to split a bit. I think there was a lot of splitting between the nurses and the psychologists and having a couple of Trainees, like the Aboriginal Trainee and the Enrolled Nurses that come in, really brought a balance back. These guys were a common link, I guess, for everyone and it has really brought a nice balance back to the team. (Manager)

- By contributing to the professional development of the Trainee, the team also develops around a common purpose.

I think that this approach [AMHWTP learning model], you have got ownership from the actual Mental Health Service and the actual teams, not the other way around. Before there was ownership from the Uni and the team placement was just seen as an adjunct to the Uni experience, I guess. But now the teams actually consider the Trainees to be their clinicians that they are nurturing up, that at the end of the day, to be Aboriginal Mental Health Clinicians, so they're wanting them to be up and able to operate in a really good way, so they are actually contributing to the development. So it is the best I have seen. (Team Leader)

- Having Trainees encourages and facilitates reflective practice within the team. Mental Health Workers are required to reflect on their own practice in order to explain how and why they cared for and managed a client in a certain way.

It makes you lift your act... I need to think why am I doing that so I can explain it to them. There seems to be a culture among Mental Health Workers that this is a positive thing about training the next lot of [workers]. (Team Member)

- Trainees can feed back to team members and raise their consciousness about gratuitous language they inadvertently used when talking about clients and the negative attitudes they seemed to be expressing. Bringing these to the attention of the team can result in a more positive team environment.

... Then another issue for us was I think it was just the cynicism, you know, like I understand that people get cynical when they are in their jobs but I felt that it was our people they were talking about and I didn't like it, and there was also issues relating to a community member who is a client and it was like they were sort of, you know how someone says, 'Oh, they're not going to make it'. They have this really sad attitude towards clients and it wasn't even just Aboriginal clients, this was right across the board and I felt really, I said, 'You know, we're Trainees, we're learning from you'. (Trainee)

- Trainees can play an important role in strengthening links between the mental health service and the local ACCHS, particularly if there is a formal arrangement for the Trainee to be placed periodically with the AMS or for the AMS worker to be placed with the mental health service.

They [the Mental Health Service] found the feedback was very beneficial and the Trainee enjoyed attending here, so that the days increased. I know he attends regularly our men's meeting which is once a month. When they approached us to increase his hours here, I felt that I needed to utilise his skills and we've recently received funding for an adolescent mental health worker. So I'm going to utilise the Trainee and his resources to do the foundation work for that program before the adolescent worker is employed. And that's about networking also, linking the new employee into [the mental health service] to support the young boys. So if he has understanding of the foundation of the new position, then the partnership will run smoother. (Team Leader)

- Practically, a Trainee is an extra resource for the team and is particularly important in small teams who do home visits requiring two staff for safety.

If a person [a client] is not travelling too well and, you know, occupational health and safety, you should take two people... It takes the pressure off [the team], because instead of another case manager having to go, we have got two people there, so it makes it safe. Even though one is a student, it is still that safety person there. (Manager)

Benefits for Aboriginal clients and communities

- The Program builds the local community's capacity with regard to mental health literacy and knowledge of a mental health services. Trainees, as members of the local communities and organisational networks, are able to transmit information and translate 'government speak' and the language of mental health into understandable words and concepts.

Just more education for our community and the better it is going to be for us... (Trainee)

- Trainees take their knowledge about mental health services and what they can offer into the community.

So I think working here has been a real highlight for me. Just getting to know, like the Area Health Service, the way they work and working at a hospital. It is really important you know and letting our people know that we are here even though we are only Trainees and that's what we have to say to them, 'We're here but we are only students but we are still here to advocate for you'. (Trainee)

- Trainees provide insights to other clinicians about Aboriginal culture and family life that can improve client care.

What I do when we get Aboriginal clients, is that I do a lot of, I guess, background research. I consult with their community case workers, with their family, with anyone that I can, because we get a lot of patients from [towns] and all these kind of places and being a black fella, you know a lot of different people in a lot of different places. So I guess what has actually happened in the last three or four months is that a lot of these psychiatrists have come out from Sydney, while they have had experience with working in the country, they don't really have a lot of knowledge about who these people

are and where they come from and all these other things, which I guess I know. So the doctors use me quite a lot in doing that. (Trainee)

- Trainees act as ‘cultural brokers’ to increase the team’s knowledge about Aboriginal culture.

They [overseas trained doctors] utilise me quite a lot, even to the point where they are asking me, what particular word means in Aboriginal culture and they are asking me, why does it impact on the community?... I have had to explain to them, that is it not just mental health, but health to Aboriginal people is everything. It is their world and often mental health is linked with a lot of other things that are going on with their body and outside, you know, their life, their social life, their employment, their education and all of that kind of stuff. Feeling unwell is also linked to a lot of physical stuff. I have often got to explain to them a couple of cultural stories which a lot of our clients do talk about. Like they talk about ghosts and spirits following them, and then I have just got to talk to the doctors about that and they are quite open and they like listening and understanding. (Trainee)

- Mental health services can offer a more responsive service to Aboriginal clients.

I think enhancing the existing team in another direction. It is almost like expanding the scope with a multidisciplinary approach. We have got some people who can really enhance it from [an Aboriginal perspective], so that is good. You know they are going to be generic mental health workers, but I would imagine that they would be used as specialists with the Aboriginal community. So they are really excited about that... so just the enhancement of the team, the ability, the potential now for the team to really realise that they can reach the Aboriginal population and people of their own, which I think is always the best. (Education Officer)

- Trainees have access to networks of other Aboriginal workers in departments and organisations through which collaborative action and client care are possible.

So we’ve got this really great communication. I go to a meeting every six weeks with the police and DoCS and Housing on the Aboriginal clients, so if there’s been domestic violence, DoCS and police and myself know about it... If they’ve got people that have been presenting with DV, they tell DoCS. ‘Is this person a client of yours?’ ‘No.’ ‘Well, maybe we need to make some referrals; maybe we need to chase up.’ If they’re my clients, I go in and tell them you know, ‘You are on notice,’ and it’s working... So we’ve made networks that mainstream services haven’t got. [They] just don’t have that time to do that whereas, because I’ve been a student, I’ve had that time to make those links. And actually, I treasure those links. I back them up. (Trainee)

Benefits for NSW Health

- The Traineeship is a public and practical expression of commitment to increase the number of Aboriginal people employed within NSW Health and specifically within mental health services. There were 20 Trainees employed in 2007–08 through funded traineeships and by conversion of permanent, unfilled positions to Trainee positions. Two of these Trainees were third-year students due to graduate at the end of 2008. An additional nine Aboriginal Mental Health Worker Trainee positions will be rolled out in 2008–09, mainly to the metropolitan Area Health Services.
- The Traineeship can serve as a model for workforce development programs targeting other health professions where there are current skills shortages.

Summing up

A Manager expressed this view about the Training Program:

It is good to see Aboriginal Mental Health back on the agenda. Because we have all got Aboriginal people living in our communities and we all know that not many of them access [mental health services]. So it was great that we are working towards providing that service again, that we really haven't done for a few years. And I think everyone appreciates that and everyone appreciates that now we are going to have these experts to help us, because I think that most clinicians feel that they maybe don't do the best job that they can with Aboriginal clients.

A Reference Group member contributed the following comment about the Program and process of implementation and support:

I mean for me it's been incredibly interesting in terms of you know, everywhere you go and talk about this Program everyone's excited about it and supportive of it and that type of thing. And that's a rare event in any program, let alone an Aboriginal program, so you know that's been a really good thing.

FUTURE DEVELOPMENTS

This report documents the first year of the Aboriginal Mental Health Worker Training Program. The State-wide Program has had a good beginning. It has a strong policy framework, Ministerial Executive champions and Area Health Service support. However, it is a work in progress. A large body of work remains to be undertaken to ensure that the Program is strong and sustainable. The following activities and projects have been identified to further develop the Program:

- Further development of policies and procedures specifically for the *Aboriginal Mental Health Worker Training Program Manual*.
- Development of the State-wide *Aboriginal Mental Health Worker Training Program Manual*.
- Establishing formal links with other agencies and services to strengthen mental health service delivery to Aboriginal people.
- Development of a communication strategy for the Training Program. The strategy will address communication across the Area Health Services, across NSW Health and with other providers and the community.
- Establishment of a monitoring and evaluation framework for the Program.
- Development of career pathways for Aboriginal Mental Health Workers.
- Establishment of an agreed scope of practice for Aboriginal Mental Health work throughout NSW.
- Identification of suitable tertiary programs that meet the workforce needs of Training Program.
- Development of academic pathways and articulation to a range of university degrees.
- Development of comprehensive Memoranda of Understanding between NSW Health and education providers.
- Identification of resources, particularly human resources, needed to train and support an Aboriginal Mental Health Worker.

A number of additional strategies to further develop the Aboriginal mental health workforce were identified and recorded at the NSW Aboriginal Mental Health Worker Forum in May 2006 and are documented in the *Wellbeing: Aboriginal Mental Health Worker Forum Report* (pp. 39–40). This Review reinforces and adds to the list of 'next steps' recommended in the Wellbeing report.

SOUND PRACTICE IN THE ABORIGINAL MENTAL HEALTH WORKER TRAINING PROGRAM

This section collates the sound practices identified as part of the Review, and presented throughout this document.

Summary of sound practice in workplace preparation

- It is important for Managers to have a process for assessing a mental health team's capacity to incorporate a Trainee into the team to ensure that the Trainee will be well supported.
- Mental health teams who had the capacity to support a Trainee described the Trainee as fitting in with the overall work of the team. These teams usually had six or more staff, at least two of which were senior clinicians.
- Multidisciplinary teams were able to offer Trainees varied experiences and different occupational perspectives.
- Community mental health teams provided Trainees with the opportunity to observe the range of mental health services from prevention to acute care, home and in-patient visits.
- Support staff who had been briefed about the aim and objectives of the Program, the role and expectations of the Trainee and their roles and responsibilities in training and supporting the Trainee, reported more positive experiences than those who were not thoroughly briefed.
- In teams that had prepared an office space and identified support people beforehand, Trainees reported feeling welcomed and supported.

Summary of sound practice in recruitment

- A good position description clearly stated that the Traineeship encompassed full-time work and full-time study, and that successful performance in both are required for continued employment.
- Area Health Services that used a variety of media (internet, local papers, and Indigenous media) and networks to advertise the Trainee positions received a large number of applications.
- Involving the local Aboriginal community in the recruitment process ensured a positive response to advertisements and willingness to engage in the ongoing support of the Trainees.
- Involvement of the Aboriginal Health Unit in the recruitment process had a number of benefits, including access to Aboriginal expertise and networks and ongoing support for the Program.
- When there was a balanced panel with Aboriginal representation, questions made available before the interview and a comfortable venue, Trainees expressed a positive view of the interview process.
- Allowing sufficient time for the criminal record check and adopting a flexible approach if the suitable applicant had a past criminal record were identified to be important considerations.
- Trainees and their support staff reported a smoother transition to combining work with study when Area Health Services began recruitment processes in time for Trainees to spend at least three months in the workplace before they began university studies.
- Consideration of a Trainee's life, work and study experiences enabled the workplace to put suitable structures and processes into place to support the Trainee's development as a mental health professional.

Summary of sound practice in workplace training and support

- The Traineeship was working best in teams where the managers and team members understood the Program aim, objectives and expectations.
- Managers who established clear boundaries around what Trainees could do at any given time in the Traineeship provided a safe working environment.
- Area Health Services that allocated experienced preceptors and clinical supervisors to the Trainees were providing a high level of on the job training for the Trainees.
- A thorough orientation and induction process during the first three months provided a good foundation for Trainees to learn about mental health, the workplace and the related community organisations and services.
- The *Aboriginal Mental Health Worker Training Program Manual* was reported to be valuable in providing guidance.
- It was reported to be important for teams to know they had policy direction and support for the Training Program from the Minister, senior management, the State-wide Coordinator and the Reference Group.
- Area Health Services that established formal groups or mechanisms to guide the operation of the program were able to provide support both to the Trainees and their managers.
- A wide range of informal supports were being provided to Trainees or Trainees were organising them for themselves.
- Cultural mentors provided important additional support and guidance for Trainees inside and outside the workplace.
- Documentation of training and support activities, including time allocated to the Traineeship, was important for monitoring and evaluation.

Summary of sound practice in combining work and study

- Having a preceptor, supervisor and team members who were available to discuss assignments directly assisted the Trainee in completing them and increased the knowledge about the university component of the Traineeship.
- The more managers, clinical supervisors and preceptors knew about the university's expectations the better they were able to support the Trainee.
- Having an allocated study day during the week between residential teaching blocks and resources such a laptop computer enabled Trainees to more easily complete university requirements.
- Trainees who were able to organise a tutor reported that it had helped them with their time management and ability to understand and complete their assignments.
- Undertaking placements in the same geographic area in different health services, programs and local AMSs contributed to building an understanding of the Training Program and strengthening links between services. It also decreased the Trainees' stress by not having to be away from family and support people.
- Having realistic expectations about what can be reasonably expected of a Trainee at each stage of Traineeship was viewed as very useful by both Trainees and teams where they were applied.

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APPENDIX 1: RELATIONSHIPS AND GOVERNANCE OF THE NSW ABORIGINAL MENTAL HEALTH WORKER TRAINING PROGRAM

Relationships and Governance of the NSW Aboriginal Mental Health Worker Training Program

REPORTING RELATIONSHIPS AND GOVERNANCE	MEMBERSHIP AND RELATIONSHIPS
NSW Mental Health Program Council	Mental Health and Drug & Alcohol Office Senior Management Director, Mental Health and Drug & Alcohol Programs Area Directors of Mental Health Services NSW Institute of Psychiatry Justice Health Children’s Hospital Westmead Centre for Rural and Remote Mental Health Mental Health Coordinating Council NSW Older People’s Mental Health Policy Unit InformMH MH-KIDS
Continuing Care, Rehabilitation & Recovery Working Group	Mental Health and Drug & Alcohol Office Mental Health Program Council State-wide Services Development Health Services Performance Improvement Branch Area Directors of Mental Health Senior Clinicians/Service Managers InformMH Mental Health Coordinating Council Justice Health Consumer rep. through NSW Consumer Advisory Group
State-wide Reference Group	Mental Health and Drug & Alcohol Office All Area Health Services Workforce Development Branch Centre for Aboriginal Health Charles Sturt University (Stage 1) State-wide Coordinator
Aboriginal Mental Health Workforce Program State-wide Coordinator Operational Reporting to Greater Western Area Health Service Strategic Reporting to Mental Health and Drug & Alcohol Office	Mental Health and Drug & Alcohol Office Stage 1–10 newly funded positions and operational responsibility (2) Greater Western (2) Hunter New England (1) Justice Health (2) Greater Southern (2) North Coast (1) North Sydney Central Coast Stage 2–9 newly funded positions and operational responsibility (2) Sydney West (2) Sydney South West (1) Justice Health (2) South East Sydney/Illawarra (1) Hunter New England (1) North Sydney Central Coast

Table developed by Tom Brideson

APPENDIX 2: DEMOGRAPHIC PROFILE 2007 TRAINEE COHORT

The following demographic profile is based on information obtained during one-to-one interviews with 12 Trainees employed across the four rural Area Health Services, Northern Sydney Central Coast Area Health Service and Justice Health. Two Trainees who were employed by ACCHS were interviewed but their data have not been included in this profile. A group interview was conducted with nine Trainees employed in Greater Southern Area Health Service. No demographic information was collected from the group.

Of the Area Health Service employed Trainees, 10 were first-year Trainees and two were third-year Trainees who had been undertaking the Bachelor of Health Science (Mental Health) at their own expense. Both were employed as Aboriginal Mental Health Workers in their respective mental health services prior to becoming Trainees.

DEMOGRAPHIC PROFILE AREA HEALTH SERVICE EMPLOYED TRAINEES N=12

Sex	Female	7
	Male	5
Age	Range	20 years to 55 years
	Average Age	36
School Completion	Year 9	1
	Year 10	7
	Year 11	1
	Year 12	2
	Not Known	1
Vocational Training	Certificate 3 or 4	9
	Associate Diploma	1
	Diploma	2
Previous Tertiary Experience		1
Work Experience²⁵	NGO	5
	Public Service	8
	University/TAFE	3
	Private	4
	CDEP	2
Family Responsibilities	(children, grandchildren)	9

²⁵ Some Trainees had worked in a variety of jobs for different types of employers. For example, one Trainee had worked for the private sector and for two different government departments.

NSW ABORIGINAL MENTAL HEALTH WORKFORCE PROGRAM

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