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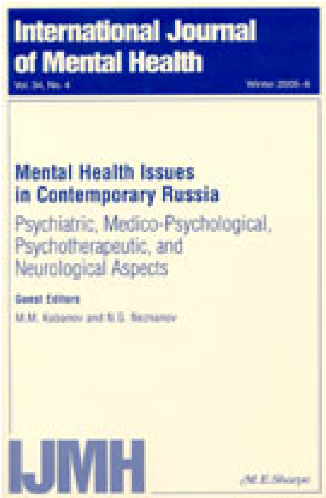

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Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models

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Abstract: The purpose of this article is to identify issues affecting the clinical supervision of the Aboriginal and Torres Strait Islander mental healthcare workforce, and propose alternative supervision models. Participatory Action Research (PAR) was the primary methodology used to elicit and analyze the reflections of five Aboriginal counselors. The data highlighted a number of inadequacies with current practices that typically lead to high levels of stress and burnout. We recommend the implementation of alternative supervision models including the use of cultural supervisors, and dual supervisors; and accessibility to consultation, supervision, and communities of practice for remote workers through modern technologies.

Keywords Aboriginal and Torres Strait Islander mental health; clinical supervision; indigenous workforce development; cultural understanding; burnout

The prevalence and incidence of serious mental illness and general distress in Australia's Aboriginal and Torres Strait Islander community are substantial [1, 2] and have been causally linked to historical trauma [3, 4] and current levels of disadvantage and disengagement [5, 6]. A recent focus on developing workforces to manage mental health issues effectively in this community, preferably with indigenous representation [7–9], has revealed that it is not an easy task and that there are a number of significant recruitment and retention challenges

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[10–13]. Arguably, it is much harder for Aboriginal and/or Torres Strait Islander practitioners to manage their workplace obligations than for their non-indigenous counterparts for a number of reasons [14–16]. For instance, practitioners and clients typically have shared histories of being exposed to the same stressors and social determinants. Practitioners also have the challenge of balancing their workplace and community obligations when, for most, their clients and workplaces are in their home community. Furthermore, Australia is the sixth largest country in the world (close to the size of the United States) with a population of less than 24 million people. Around 50 percent Aboriginal and Torres Strait Islander health professionals live and work in some of the remotest parts of the continent where local professional support is extremely limited [17]. As such, the need for access to and utilization of clinical supervision that enhances clinical skills and supports self-care and positive wellbeing is paramount for both professional and personal reasons. At the same time, providing this support may require considerable creativity and the need to develop a variety of different supervision models for different contexts.

A previous article in this series reported findings from a participative action research (PAR) study that investigated the perceived effectiveness and acceptability of cognitive behavioral therapy (CBT) when used by Aboriginal and Torres Strait Islander counselors with Aboriginal and Torres Strait Islander clients. The results of that study along with invited international and Australian commentaries and a formal response to the commentary were recently published [14, 18–22].

Through extending the PAR methodology of the original study [23], the present article reports study data specifically related to supervision and support issues and the challenges experienced by Aboriginal and Torres Strait Islander practitioners at the ground level. Based on the research participants' reflections, we propose the need for innovative supervision models for Aboriginal and Torres Strait Islander health practitioners that specifically address the complexity and difficulty of their working conditions. This investigation is an important area of enquiry and one that, until recently, has been largely overlooked by the Australian research community [24]. However, in recent years, health service reviews, reports, and research have identified the need for establishing appropriate supervision, support, and professional development for the Aboriginal and Torres Strait Islander workforce [7, 15, 16, 24]. In particular, a first culturally appropriate supervision model, Our Healing Ways, has been proposed [15].

While the research participants in this study are qualified counselors, this article addresses the clinical supervision needs of all practitioners (e.g., Aboriginal health workers) working with mental healthcare issues in indigenous communities. To our knowledge, this is the first journal article that has specifically sought the views of Aboriginal and Torres Strait Islander mental health practitioners about the supervision needs of the workforce. It is also the first article to propose a set of alternative supervision models to meet their diverse needs.

METHOD

The reader is referred to Bennett-Levy et al. [14] for a comprehensive overview of the original study design, data collection and analysis, and interpretation. Here we note that the participants were five Aboriginal and/or Torres Strait Islander counselors who undertook ten days of formal training in CBT. An initial four-day training in core CBT skills (e.g., agenda and goal setting, Socratic questioning, thought and activity monitoring, and behavioral experiments) was followed three months later by a five-day training focused on the treatment of anxiety disorders and depression. This training was based on the core CBT skills identified in the recommended course textbook [25] and on evidence-based, high intensity CBT approaches to the treatment of anxiety and depression [26, 27]. A further day of training in "low intensity CBT" [28] was provided at the request of the counselors. All counselors possessed university-level mental health qualifications, had a current caseload, were working with indigenous clients, and received clinical supervision.

The study methodology was based on a Participative Action Research (PAR) approach [23] extending over a 15-month period. PAR has been recommended as an appropriate research methodology with indigenous communities [29–31]. Reflections on the need for effective supervision of indigenous practitioners and the inadequacy of current models emerged during the latter stages of the Action Research Group (ARG) meetings and became an important focus. This article focuses specifically on these reflections. The Southern Cross University Human Research Ethics Committee provided Ethics approval (approval number ECN-10–111).

RESULTS

The main themes from the qualitative analysis are summarized in Table 1, which identifies the following key elements.

Community Context: "The Blur"

Access to effective clinical supervision was raised as a topic in reflections focusing on the challenges associated with being Aboriginal or Torres Strait Islander mental health practitioners

TABLE 1
The Need for Effective, Safe, Cultural Apporpriate Clinical Supervision for Indigenous Health Practitioners

Contexts		*Supervisory Models*
Community Context – The "Blur" • The "Blur" – Community is home, family, friends – and clients • Family as co-workers and clients • Confidentiality risk • 24/7 vigilance	**Supervisory Context** • Lack of availability and retention of skilled supervisors • Dependencies and demands on supervisors/supervisees • Formal vs. informal supervision • Trying to protect supervisor through non-disclosure	**Current Supervision Models** • Inadequacy of current models • Non-Indigenous supervisor without community understanding • Non-indigenous supervisor with community understanding • Peer supervision model
Duty of Care • Underqualified workforce • Burnout and sustainability • Need for self-care • Safety/trust/confidence in supervision • Supervisee education, expectations, and skills	**Supervisor Competencies** • Supervision for knowledge/skills • Supervision needed for personal and professional issues – Boundaries • Structured approach to supervision	**Proposed Alternative Supervision Models** • Dual supervision model • Cultural and community education • Consultation for skill development • Communities of practice • Supervisor training

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working in and with their own community. The Aboriginal community is not governed by location or the proximity of people who belong to it. Rather, it is a network of family and social relationships that are not severed by time, distance, or incident. As such, those who choose to work as counselors with their own people struggle with the unavoidable tension between the often conflicting obligations of the community and the profession. Members of the ARG named this conflict as "the blur" (see Table 1). Most of the group reflected on occasions when they were *required* to work with family members, friends, or other associates with whom they had shared positive and negative experiences. Providing psychological support in this environment was experienced as difficult—especially when a counselor is the only therapist available and the need for intervention is high. Professional boundaries and community/cultural obligations are commonly stretched to the breaking point, impinging substantially on professional and personal wellbeing.

Family and other close associates may be not only coworkers or clients, but also people identified as perpetrators in incidents of physical and sexual violence. When such a situation occurs, the effects on the wellbeing of the counselor are considerable. As well as the personal distress involved, a referral to police or child safety often results in being confronted in your own home or having family members confronted in the street or at their school. As one practitioner pointed out:

> If it's mandatory reporting, how are you protected if you actually make the report? And we know that the success rate of convictions around this sort of stuff… it doesn't take too much to work out where it's come from.

Members of the ARG discussed the "mandatory reporting" quandary at length. Everyone acknowledged the requirement to report but questioned its aftermath. Most of the group shared at least one negative experience relating to the process, viewed reporting as ineffective, and reflected on how difficult reporting had made their lives. The role of the supervisor in these cases is to promote professional practices and to support the supervisee when profession and life collide. Members of the group advised that often they filtered what they shared in supervision because they were not confident that their supervisor was sufficiently competent in navigating community matters. Even though nondisclosure was discussed, all ARG members agreed that this approach was unprofessional and had the potential to damage their personal wellbeing.

Recipients of mental health services have a right to expect that information shared in sessions will remain confidential and only be discussed under agreed conditions. Members of the ARG highlighted the difficulty associated with managing confidentiality and expectations of confidentiality in their own communities. They pointed out that, in most communities, information and knowledge are public property and are freely discussed. Practitioners in small communities face difficulties when clients are seen coming and going from the counseling center; family members ask direct questions about people (identified by name) who had been seen there. Refusing to share information with significant others is often interpreted as disrespect and leads to family and community unrest.

The alternative assumption that confidentiality will not be maintained was also identified as a major impediment to therapeutic progress in Aboriginal communities. Members of the group found it interesting that previous clients would refuse to disclose information because of confidentiality concerns when it was clear that the therapist and most of the community knew about what

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was being withheld. In all cases, however, members of the group understood the importance of the client feeling safe enough to share information, regardless of who else knew about it.

> Probably the biggest thing I've found for myself, personally, and professionally is dealing with issues that I myself have faced or are still facing: suicide, teenage pregnancy, all that sort of stuff —drug and alcohol abuse, criminality, prison.

Another set of beliefs identified as problematic when working as a counselor in one's own community include having to be available for consultation at all times; having to answer all questions; and being well paid and happy enough to sponsor others who are struggling. It was clear from the discussion that the normal stresses associated with being a counselor were magnified by the need to manage community expectations and say "no" when everything inside is saying "yes." When we also consider that most members of the group continue to manage the impacts of their own histories, the case for the provision of best-practice supervision is obvious. How to provide effective supervision is the focus of this article.

Duty of Care

The Australian Psychological Society estimated in 2013 that only fifty Aboriginal psychologists were working in Australia [32]. From this number, one must assume that most of Australia's indigenous mental healthcare practitioners are not psychologists and have not experienced the depth of education and supervision normally experienced by psychology graduates. It was generally agreed by members of the ARG that their levels of qualification were less than demanded for a similarly situated non-indigenous mental healthcare worker. They did, however, agree that their levels of experience were comparable with others working with Aboriginal and Torres Strait Islander clients and that they were conscious of "too often" working "beyond their competencies." Nonetheless, members of the ARG believed that their management of clients was professional and effective. There was, however, concern about levels of organizational responsibility and of care in situations when they were required to work with particularly complex clients.

They shared the opinion that their stress about working with complex clients was exacerbated by the fact that they might know the families of their clients and that they often assumed unsafe levels of responsibility for their clients' wellbeing. While they agreed that their perception of responsibility contributed to burnout, they were in a position where "falling over" was not an option. The feeling of responsibility was linked to their community ties and not to their professional roles. As one member pointed out:

> So, the burnout may not be from what's happening on the job, it's from what you're not going into the job with. That's why people are falling over. And so supervision can only take you so far.

There was universal agreement that becoming more skilled and confident as counselors and being supported to meet their own wellbeing would reduce job-related stress. Members of the ARG were balanced in the way they viewed their situation. They knew the benefits of additional professional development and support but also acknowledged the expense of regional and

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remote service provisions. There was, some would argue, a strong tendency toward self-sacrifice, preferring that money be allocated to clients and not workforce development.

> [A]nd some days I couldn't face anyone. I was living in … by myself, there was no supervision. I'd wake up and I'd just disappear. Which, you know, breaks all the rules, but … it's a hard role.

There was serious concern within the group about the number of practitioners (not only themselves) who were required to work in relative isolation without access to immediate support when needed. While the group agreed that this arrangement was dangerous and a potential breach of duty of care, they all agreed that they had worked in similar situations previously.

It was telling that members of the group, at different times, chose to share how difficult their personal situations were and how concerned they had been about their own wellbeing. While most could list their self-care activities and identify how often they were (under) used, they struggled to identify what their employer organizations had provided. Members of the group revealed that being provided with clinical supervision was included in their contracts, but such supervision was rarely provided. Participating in the project ensured access to and utilization of effective clinical supervision and membership into a "community of practice" that continues to exist and support its members. While the group acknowledged the difficulties associated with providing supervision, they felt that unprofessional supervision should not be tolerated:

> So, and I've had people [supervisors] say, when I talked about a client whose been raped or gang raped, or—and blah, blah, blah. And they go, "Well, isn't that what always happens in Aboriginal communities?"

At a time when establishing and maintaining an Aboriginal and Torres Strait Islander mental healthcare workforce is emphasized, the group argued that "duty of care" was an issue that needed to be rectified. Worker support should be viewed positively as an investment not as an avoidable expense.

Supervisory Context

The PAR group maintained that skilled supervisors who could effectively address the specific challenges facing indigenous counselors were

1. in very limited supply,
2. often very expensive, and
3. difficult to retain.

Trusted supervisors were often lost because they had moved to other roles/locations, became too busy with other duties, or because providing indigenous supervision had become too difficult. Members of the group were clear in their belief that for supervision to be effective with counselors in particularly challenging roles (in the current context, those working in Aboriginal and Torres Strait Islander communities), professional *and* personal issues need to be addressed and monitored. As such, the group thought that suitable supervisors would have to possess an adequate working knowledge of how indigenous communities operate and how best to work with supervisees who struggle with the dual roles of practitioner and community member. When

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suitable supervisors are not available, practitioners rely on informal methods of supervision, which may be more damaging than beneficial.

> When I used to come back from community and go I just dealt with this, this and this, their lip would be quivering. I'd go, "Okay, hold it together, this is going to get uglier, so just breathe. You're going to hear some things that you really don't want to hear." But I need to offload them.

The counselors also reported filtering information they shared in supervision because of concerns for their supervisors' feelings. If they shared too much, they feared that supervision would be discontinued. A majority of the group used this strategy because of their fears about losing supervision and not being able to find a suitable replacement.

Supervisor Competencies

For supervision to be maximally effective, the ARG argued, it should focus on knowledge and skill development, facilitate access to cultural guidance when required, and support wellbeing and self-care. The clinical supervision literature is very clear in restricting the focus of supervision to professional matters only and the need to refer if therapy is considered beneficial for the supervisee. While the group agreed with the intent of the clinical focus, they struggled with the referral process, arguing that their supervisor is sometimes the only individual that they trust to share their concerns, and the only locally available counselor. Our data already suggest that Aboriginal counselors might often benefit from counseling and that such an arrangement would provide organizational benefits. The consensus of the group was that members got much more out of supervision if the focus was shared between professional development and personal support, with the latter on an as-required basis. Supervisory competency becomes critical when decisions about referral for therapy arise, especially when referral pathways are non-existent.

The competency that was most respected by the group was that of working within a clear understandable structure that allowed sessions to be organized and effective. All of the ARG members were able to contrast supervisory experiences that were chaotic and ineffective with others that were structured and meaningful. Most, however, spoke fondly of sessions that allowed both professional and personal matters to be managed and/or resolved.

DISCUSSION

To our knowledge, this article is the first that has mapped the perspectives of Aboriginal mental health practitioners about their experiences of supervision. Members of the ARG group voiced their appreciation of effective supervision but raised a number of issues pertaining to difficulties securing and maintaining a beneficial supervisory relationship. While all members recalled some positive supervision experiences, a number shared less favorable experiences, such as filtering the content of their sessions for fear that their (non-indigenous) supervisor would be distressed by their disclosures and terminate their relationship. The issues that contributed to higher risks of burnout and compromised mental wellbeing were perceived by members to be specific to being indigenous and working within their own community, included boundary violations, family as clients, associates and family identified as perpetrators, working beyond competencies, and feeling that failure was not an option. The ARG members also highlighted the fact that their own past experiences often echoed current difficulties of clients and that these constant reminders sometimes made it difficult to manage their own distress.

The stories and reflections of the ARG group made a number of points very clear. First, they were working under very challenging and potentially damaging conditions. Second, they remained in their professions because of a sense of duty to their people and their communities. Third, the need for effective supervision and support was high, and whether that need had been acknowledged was questionable. As a rule, they were not satisfied. Members of the group were not interested in blaming or complaining; they were more interested in discussing what types of supervision would work for Aboriginal and Torres Strait Islander counselors and how they could be implemented in a cost-effective and sustained manner.

Several conclusions emerged. First, all members of the group valued supervision. Second, positive supervision experiences were relatively uncommon. The two supervision models identified as being the most common and the most ineffective were (1) having non-indigenous supervisors with little or no community understanding, and (2) being required to participate in peer supervision with other practitioners lacking clinical expertise. A third conclusion was that differentiating between the professional and personal self and limiting supervision to the professional is not appropriate, ethical, or cost-effective in this circumstance.

For supervision to be effective, the group identified three essential components:

1. clinical expertise for skill acquisition and development;
2. personal support recognizing the specific issues (e.g. “the blur”) faced by Aboriginal and Torres Strait Islander practitioners; and
3. cultural/community understanding that informs the clinical and personal support.

While a combination of these three components in one supervisor would be ideal, members of the ARG recognized that supervisors who possessed this skill-set were few, such supervisors would likely be in high demand, and that the probability of working with them would be low. Their pessimism related to beliefs that their organizations would not pay for higher-level supervision, that often the qualifications of Aboriginal mental health practitioners were comparatively lower than similarly circumstanced non-indigenous workers, and that challenges associated with working remotely were insurmountable.

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PROPOSED SUPERVISION MODELS

As a result of the discussions, members of the ARG proposed a number of alternative supervision models that they believed could be professionally effective, cost-effective, and feasible even when access to supervision is restricted. ARG members agreed that access to web-based, video-conferencing platforms such as Skype, WebEx, and Adobe Connect broadened their scope when considering how remote supervision could be provided. Access to these types of communication was thought to be pivotal to establishing a “community of practice” (see below) between practitioners working and living remotely and to the implementation of the suggested supervision models. While acknowledging the potential value of remote supervision, the group

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was clear that remote supervision should not be used to withdraw face-to-face sessions (when available), nor should it effectively limit the content or intention of supervision. Rather, it becomes an alternative vehicle through which supervision is provided. The following supervision models emerged from discussions:

Dual Supervision

This model was developed in response to the perceived shortage of practitioners capable of providing supervision encapsulating the three key components previously identified (clinical expertise, personal support, and cultural supervision). Dual supervision proposes engaging two supervisors: 1) one with demonstrated proficiencies in professional development and skill acquisition, and 2) one providing services in a manner that balances professional and community (cultural) obligations. Supervision could be provided either sequentially (single supervisor with supervisee), concurrently (two supervisors with supervisee), or in a group format (single or dual supervisors with a group of supervisees).

While members of the ARG were confident about their professional and community competencies, they conceded that it was often difficult to practice when professional and community obligations conflicted and cultural expectations were high. Dual supervision was favored because of its potential to facilitate more objective appraisals of client concerns, to strategize and plan with clinical and cultural assistance, and address matters of personal wellbeing in a safe and supportive environment. The extent to which this model would assist practitioners would be a product of both the suitability of the supervisors, their capacity to work together for the benefit of the supervisee, clear agreements about roles and responsibilities between the supervisee and the two supervisors, and the period of supervision (resourcing considerations).

Culture and Community Education Model

The model was developed in response to the group's perception that there were too many practitioners and supervisors (indigenous and nonindigenous) without a working knowledge of and respect for the local culture. The implementation of this model would require input from an Aboriginal or Torres Strait Islander person with extensive cultural knowledge and capacity to teach and guide practitioners and supervisors from other regions and cultures.

The Australian Psychological Society [33] requires its practitioners to possess high levels of cultural understanding prior to engaging with Aboriginal and Torres Strait Islander clients. It warns that services should not be provided without confidence that relevant competencies and knowledge are possessed. That the Australian Indigenous Psychologists' Association has delivered cultural competency workshops to over 1,000 mental health practitioners [34] is viewed as encouraging. The PAR group argued that having generic cultural knowledge is not enough and that local or community-specific cultural information was also needed. Up-skilling of practitioners and supervisors through the culture and community education model is hypothesized to increase the supervisee effectiveness and, in time, the number of potential supervisors available.

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Consultation Model for Skill Development

Aboriginal health practitioners often work in relative isolation with limited opportunities for skill development. In the United States, an extended consultation model using internet-based technologies is being increasingly utilized for developing skills of practitioners working remotely [35]. Training studies show that the gains from training workshops on their own are often minimal, and that extended group training via consultation is an appropriate and effective option [36, 37]. In the consultation model, a clinical skills expert provides didactic and skills-based training and may sometimes provide additional case consultation/clinical supervision. Topics for the training are often generated by the group and decided in advance [37] so that the expert can prepare a session tailored to the group's needs.

Development of Communities of Practice

Concurrent with the consultation model, indigenous health practitioners might benefit considerably from the implementation of a community of practice model. The term "community of practice" describes one of the oldest forms of human skill-learning activities [38]. It refers to a group of people coming together to share tips and best practices, ask questions of their colleagues, and provide support for each other with the expressed purpose of developing and enhancing a specific set of skills. Communities of practice have been found to facilitate interprofessional learning and communication powerfully, regardless of members' geographic proximity [39]. In a virtual environment, a community of practice can utilize communication technologies such as internet, video conferencing, and the telephone to facilitate skill sharing and development processes among a group of geographically diverse practitioners.

The idea for the community of practice model emerged organically from the direct experience of the ARG members, whose model developed its own momentum. The ARG worked closely over the duration of the study in efforts to ensure that everyone benefitted from participation and that everyone was satisfied. The practice of regularly checking up on one other developed early and continued throughout the study. While there were preexisting relationships, the study brought the group into a supportive community that has, on a number of occasions, provided crucial support at critical times. The *community* has also been proactive in facilitating peer supervision and arranging access to specific skills with which members believed they were not confident and which would be beneficial for them and their clients.

The community of practice model that we have proposed relies heavily on access to web-based communication (such as WebEx or Adobe Connect) and a commitment by participating practitioners to engage in regular meetings and complete homework out of sessions. The model also suggests retaining the services of a well-credentialed supervisor to work with a community of practice and to facilitate further professional development and skill acquisition when necessary. Accredited supervisors could be recruited to these positions (see the following section).

Supervisor Training Model

This model emerged out of discussions about the need for and relative scarcity of supervisors who can be relied upon to provide effective supervision with Aboriginal and Torres Strait

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Islander practitioners. The focus of this model is on developing a high level of supervisory expertise and maintaining it through a higher-order level of accreditation, supervision, and ongoing development and assessment. To qualify as an accredited supervisor, clinicians would have to complete successfully competency-based training in professional development and counseling with Aboriginal and Torres Strait Islander peoples. Furthermore, they would have to know how to support the professional and cultural practices and decision making of supervisees.

In line with this identified need for supervisor training, the Victorian Dual Diagnosis Initiative (2012) [15] has recently developed Our Healing Ways, the first supervision model specifically oriented to delivering culturally appropriate supervision training. The three core elements of Aboriginal and Torres Strait Islander supervision that we identified in our study—professional, personal, and cultural supervision—are, to a large extent, paralleled in the Our Healing Ways model, which identifies three key components of supervision: professionals working with clients, professionals looking after themselves, and the professional's role in the organization. In Our Healing Ways, these three components are encapsulated within the overarching context of *Working within community: Enjoying the advantages and managing the challenges*. Because the Our Healing Ways model emerged from a source parallel to and independent from our own, and the models identify similar components, we have some confidence that useful and valid supervision models for Aboriginal health professionals are now starting to emerge.

Ideally, an Our Healing Ways-type model for supervisory training will be made widely available for Aboriginal health practitioners in the near future, supplemented by consultation and community of practice-type models. In the meantime, given the pressing need for effective supervision, dual supervision models and cultural and community education models may be valuable interim approaches, until there are sufficient numbers of trained Aboriginal and Torres Strait Islander supervisors. A combination of these models may help to meet the supervision and support needs identified in other recent publications (7, 16).

The supervision models proposed by the Victorian Dual Diagnosis Initiative and our ARG are feasible and potentially cost efficient. If the provision of supervision in organizations servicing regional and remote Aboriginal and Torres Strait Islanders was considered an investment and not a cost, it is likely that a more effective and experienced workforce would be developed. A health economics study of the value of supervision for Aboriginal health practitioners would be most valuable.

In summary, we suggest that an investment in providing best-practice supervision may well reduce future costs associated with cyclical workforce recruitment costs and the long-term costs of unmanaged mental illness. The aim of this article has been to expand on the current literature by suggesting a range of possible supervision models to meet different needs. Given the extremely challenging conditions under which Aboriginal and Torres Strait Islander healthcare staff currently work, we suggest that the investment in enhancing supervision practices is not only warranted, but should become a formalized part of employers' duty of care. The current state of indigenous mental health suggests a need for reevaluation. Addressing supervision needs and employee care seems an important step.

REFERENCES

1. Hunter, E.; Gynther, B.; Anderson, C.; Onnis, L.; Groves, A.; & Nelson, J. (2011) Psychosis and its correlates in a remote indigenous population. *Australasian Psychiatry*, *19*, 434–438.

2. Kelly, K.; Dudgeon, P.; Gee, G.; and Glaskin, B. 2009 Living on the edge: Social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander people, Discussion Paper No. 10. Darwin, Australia: Cooperative Research Centre for Aboriginal Health.
3. Hunter, E. (2007) Disadvantage and discontent: A review of issues relevant to the mental health of rural and remote indigenous Australians. *Australian Journal of Rural Health*, *15*, 88–93.
4. Parker, R. (2010) Australia's aboriginal population and mental health. *The Journal of Nervous and Mental Disease*, *198*(1), 3–7. 10.1097/NMD.0b013e3181c7e7bc.
5. Australian Research Alliance for Children and Youth. (ARACY) (2008) *Report card: The wellbeing of young Australians*. Canberra, Australia: ARACY.
6. Australian Institute of Health and Welfare. (2009) *Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples*. Canberra, Australia: Australian Institute of Health and Welfare.
7. Roche, A.M.; Duraisingam, V.; Trifonoff, A.; & Tovell, A. (2013) The health and well-being of indigenous drug and alcohol workers: Results from a national Australian survey. *Journal of Substance Abuse Treatment*, *44*, 17–26.
8. Scerra, N. (2012) Models of supervision: Providing effective support to Aboriginal staff [online]. *Australian Aboriginal Studies*, *1*, 77–85.
9. Russell, D.; Wakerman, J.; & Humphreys, J.S. (2013) What is a reasonable length of employment for health workers in Australian rural and remote primary healthcare services? *Australian Health Review*, *37*, 256–261.
10. Kowanko, I.; Prideaux, C.; Ah Kit, J.; Ordasi, L,; Kowanko, I.; Murray, H.; et al. (2007) Rural and remote Aboriginal mental health: Meeting the challenges. In *Book of Proceedings: 16th Annual TheMHS conference*, ed. P. Hanlon, S. Robertson, K. Kellerhear, C. Issakidis, V. Miller, J. Peters, et al., pp. 220–227. Balmain, Australia: The MHS Conference Inc.
11. Mental Health Workforce Advisory Committee. 2011. *National mental health workforce plan*. Melbourne, Australia: Victorian Department of Health.
12. Queensland Health. (2009) *Aboriginal and Torres Strait Islander workforce strategy 2009–2012*. Brisbane, Australia: Queensland Health.
13. ———. (2010) *Aboriginal and Torres Strait Islander cultural capability framework 2010–2033*. Brisbane, Australia: Queensland Health.
14. Bennett-Levy, J.; Nelson, J.; Stirling, J.; Ryan, K.; Rotumah, D.; Budden, W.; et al. (2014) Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT. *Australian Psychologist*, *49*, 1–7.
15. Victorian Dual Diagnosis Initiative. (2012) *Our healing ways: A culturally appropriate supervision model for Aboriginal workers*. Melbourne, Australia: St.Vincent's Hospital.
16. Watson, K.; Young, J.; & Barnes, M. (2013) What constitutes "support" for the role of the Aboriginal and Torres Strait Islander child health workforce? *Australian Health Review*, *37*, 112–116.
17. Health Workforce Australia. (2013) *Health workforce by numbers*. Adelaide, Australia: Health Workforce Australia.
18. Hays, P. (2014) An international perspective on the adaptation of CBT across cultures. *Australian Psychologist*, *49*, 17–18.
19. Bennett, S.T., & Babbage, D.R. (2014) Cultural adaptation of CBT for Aboriginal Australians. *Australian Psychologist*, *49*, 19–21.
20. Dudgeon, P., & Kelly, K. (2014) Contextual factors for research on psychological therapies for Aboriginal Australians. *Australian Psychologist*, *49*, 8–13.
21. Creed, T.A. (2014) Training Aboriginal counsellors in cognitive behavioural therapy. *Australian Psychologist*, *49*, 14–16.
22. Nelson, J.; Ryan, K.; Rotumah, D.; Bennett-Levy, J.; Budden, W.; Stirling, J.; et al. (2014) Aboriginal practitioners offer culturally safe and responsive CBT: Response to commentaries. *Australian Psychologist*, *49*, 22–27.
23. Kemmis, S., and McTaggart, R. (2000) Participatory action research. In *Handbook of qualitative research*. 2nd ed., ed. N.K. Denzin and Y.S. Lincoln. Thousand Oaks, CA: Sage.
24. Scerra, N. (2011) *Models of supervision for Aboriginal staff: A review of literature*. Sydney, Australia: UnitingCare Children, Young People, and Families.
25. Westbrook, D.; Kennerley, H.; & Kirk, J. (2011) *An introduction to cognitive behaviour therapy: Skills and applications*. 2nd ed. London: Sage.
26. Beck, A.T.; Rush, A.J.; Shaw, B.F.; & Emery, G. (1979) *Cognitive therapy of depression*. New York: Guilford.

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27. Clark, D.A., and Beck, A.T. (2010) Cognitive theory and therapy of anxiety and depression: Convergence with neurobiological findings. *Trends in Cognitive Sciences*, *14*, 418–424.
28. Bennett-Levy, J.; Richards, D.; & Farrand, P. (2010). Low intensity CBT interventions: A revolution in mental health care. In *Oxford guide to low intensity CBT interventions*, ed. J. Bennett-Levy, D.A. Richards, P. Farrand, H. Christensen, K.M. Griffiths, D. Kavanagh, et al., pp. 3–18. Oxford: Oxford University Press.
29. Kendall, E.; Sunderland, N.; Barnett, L.; Nalder, G.; & Matthews, C. (2011) Beyond the rhetoric of participatory research in indigenous communities: Advances in Australia over the last decade. *Qualitative Health Research*, *21*, 1719–1728.
30. Wilson, S. (2008) *Research is ceremony: Indigenous research methods*. Halifax, Canada: Fernwood Publishing.
31. Tsey, K.; Patterson, D.; Whiteside, M.; Baird, L.; Baird, B.; & Tsey, K. (2004) A microanalysis of a participatory action research process with a rural Aboriginal men's health group. *Australian Journal of Primary Health*, *10*, 64–71.
32. Keast, K. (2013) More indigenous psychologists wanted. *Nursing Careers Allied Health*. Available at http://www.ncah.com.au/news-events/more-indigenous-psychologists-wanted/1471/. Accessed March 1, 2014.
33. Australian Psychological Society. (2004) *Guidelines for the provision of psycholgical services for and conduct of psychological research with Aboriginal and Torres Strait Islander people of Australia*. Melbourne, Australia: Australian Psychological Society.
34. The Australian Indigenous Psychologists Association. (2014) *AIPA has delivered cultural competence training to 600 psychologists*. Available at http://www.indigenouspsychology.com.au/news/350/aipa-has-delivered-cultural-competence-training-to-600-psychologists. Accessed March 25, 2014.
35. Beidas, R.S.; Edmunds, J.M.; Marcus, S.C.; & Kendall, P.C. (2012) Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*, *63*, 660–665.
36. Lyon, A.R.; Stirman, S.W.; Kerns, S.E.U.; & Bruns, E.J. (2011) Developing the mental health workforce: Review and application of training approaches from multiple disciplines. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*, 238–253.
37. Simons, A.D.; Padesky, C.A.; Montemarano, J.; Lewis, C.C.; Murakami, J.; Lamb, K.; et al. (2010) Training and dissemination of cognitive behavior therapy for depression in adults: A preliminary examination of therapist competence and client outcomes. *Journal of Consulting and Clinical Psychology*, *78*, 751–756.
38. Wenger, E.; White, N.; & Smith, J.D. (2009) *Digital habitats: Stewarding technologies for communities*. Portland, OR: CPsquare.
39. Ardichvili, A.; Page, V.; & Wentling, T. (2003) Motivation and barriers to participation in virtual knowledge-sharing communities of practice. *Journal of Knowledge Management*, *7*, 64–77.

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