

2nd Place Winner of 2023 PIF Australian Essay Competition

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Essay topic - 'A psychiatrist's role in advocacy?'

By Kealey Griffiths

I acknowledge the Traditional Owners of the Land on which I produced this work, the Yuggera and Turrbal people. As a Yuggera woman and psychiatry-inclined medical student, I recognise that many scholars and story tellers have come before me, both Indigenous and non-Indigenous, and I hope I continue to make my family and community proud.

Great Expectations: A Story of Advocacy

As medical students, doctors and fellows of the Royal Australian and New Zealand College of Psychiatry (RANZCP), we are expected to meet and adhere to graduate attributes, codes of conduct and competencies. My Doctor of Medicine Program, for example, is built around six thematic domains which includes "Advocate for Health Improvement".

All medical practitioners are expected to follow *the Australian Health Practitioner Regulation Agency's Code of Conduct; the code posits that* "good medical practice involves using your expertise and influence to identify and address healthcare inequity and protect and advance the health and wellbeing of individual patients, communities, and populations" (AHPRA, 2023).

RANZCP fellows have seven competencies, based on the CanMEDS roles (RCPSC, 2023); one of these is "Health Advocate". As per the competencies, psychiatrists have a firm role in advocacy and should "advocate on behalf of individual patients, their families and carers, as well as more broadly, on an epidemiological level" (RANZCP, 2023).

But it would be naïve to suggest this is the end of the story; that all medical students, practitioners, and fellows are fulfilling their roles as an advocate. If they were, the individual, institutional, and structural racism that is omnipresent in our health systems and wider society would have been dismantled (at least in part) and Aboriginal and Torres Strait Islander Australians might have (more) equal health outcomes when compared to non-Indigenous Australians (Hampton & Toombs, 2013).

The (un)documented history of Aboriginal Australians and Psychiatry

Aboriginal Australians are largely absent from the documented history (or story) of psychiatry in Australia. Indeed, Duke (2007) purported that there was no mention of Aboriginal Australians in published materials until 1889, 78 years after the first psychiatric hospital was opened in Australia. Some 30 years later, a survey of the proto-psychiatric profession was published in 'The Dawn of Australian Psychiatry'. The work detailed Aboriginal peoples as "murderers of settlers" and having contributed to the name of a Queensland Asylum – "Goodna", which means 'dirty water'. In other works, Aboriginal Australians were referred to as a race that was dying out - "it is nature's way" (Thomas, 2004). The few mentions of Aboriginal Australians in the context of psychiatry were plagued by racist and eugenic attitudes and ideals. Aboriginal and Torres Strait Islander people deserve a better, more equitable story.

Indeed, significant changes have since been made; Aboriginal and Torres Strait Islander peoples are very much included in research and medical services, but problems do persist. Aboriginal Australians remain the 'subject' of research (Povey & Trudgett, 2019), experience discrimination and racism in health care settings (Hampton & Toombs, 2013) and are underrepresented in health care professions¹. In 2019, only 0.44% of all Australian medical practitioners identified as Aboriginal or Torres Strait Islander; this number drops to less than 0.2% among medical specialists and 0.1% among psychiatry fellows (Medical Board of Australia, 2021; RANZCP, 2016).

It is well appreciated that such underrepresentation in the mental health workforce is a barrier to engagement with services for Aboriginal and Torres Strait Islander people (Upton et al., 2021). When considered in combination with the way research is conducted on (not with) Aboriginal and Torres Strait Islander people, and the experiences of racism within health care settings, a clear picture of how the gross health inequity between Indigenous and non-Indigenous populations materialises. Here lies a rich opportunity for psychiatrists – we can (and should) advocate for health equity and anti-racism frameworks within the hospitals, clinics, and spaces we service. To do this successfully, and meaningfully for the communities it is intended to help, is no easy feat, but we can all do several things to begin (or continue) our advocacy journeys:

Learn about the socio-political history of so-called Australia, pre and post colonisation, from resources such as books, television (e.g., NITV) and research. Question the author's intentions and the stereotypes, attitudes, values, and beliefs they might be upholding or dismantling. Consider how you, your colleagues, and the wider structures within which we practice may benefit from these. Referring to Aboriginal or Torres Strait Islander colleagues for information that can be sought elsewhere with relative ease can add to the cultural load or burden many Indigenous professionals experience; this practice should be avoided where possible (Tujague & Ryan, 2023).

Contemporary societal attitudes, values and beliefs permeate into our own ways of knowing, being and doing; not only does the standard you walk past become the standard you accept, but it becomes the standard you enact.

Pertinent to advocating for Aboriginal and Torres Strait Islander health equity is understanding the theories and knowledge systems that underpin Indigenous lived experience. **Deliberate Critical Race Theory, Indigenous Standpoint Theory, and the Cultural Interface** in the context of your practice and own lived experience (Ardill, 2013; Lynn & Dixson, 2022; Martin et al., 2017; Moreton-Robinson, 2013;). Read and listen to the lived experiences of Aboriginal and Torres Strait Islander peoples, across a plethora of genres (e.g., memoir collection – “Growing up Aboriginal in Australia”, Heiss 2018; poetry – “Comfort Food”, van Neerven 2016; textbook – “Indigenous Australians and Health: The Wombat in the Room”, Hampton and Toombs 2013).

Explore resources that detail Indigenous Traditional Knowledge systems, such as “Dark Emu” (Pascoe, 2014) and ask yourself if you value these forms of knowledge when used in lieu of or in combination with your own (usually Western) frameworks.

Aboriginal and Torres Strait Islanders have been the traditional owners of so-called Australia since time immemorial, with deep cultural roots in the stewardship of natural systems (Gammage et al., 2021). Such stewardship is known as 'caring for Country', but recently, First Nations scholarship has been tending towards a new term: 'caring as Country' and, in doing so, highlights that this practice is multi-directional and beyond human understanding (Suchet-Pearson et al., 2013). While 'Country' provides humans with everything they need, it will no longer do so if not respected and appreciated; "if the land's sick, we're sick" (Rigby et al., 2011).

Indeed, 'caring for/as Country' activities, such as grass burning, gathering bushfood and biomedicine, protecting sacred areas, and producing artwork, contribute to superior physical and mental health outcomes, as demonstrated in several studies (e.g., Burgess et al., 2008; Burgess et al., 2009). 'Nature Rx' (i.e., prescribed time spent in nature) is a pre-established (and researched) practice in medicine (Ivers & Astell-Burt, 2023); Aboriginal and Torres Strait Islander peoples and communities have been prescribing 'Culture Rx' since time immemorial. However, such cultural prescription has been grossly impacted by the socio-political history of Australia; cultural activities and connection has been both explicitly and incidentally prohibited (e.g., Assimilation Policy and damage to natural ecosystem, respectively) (AIATSIS, 2023).

Psychiatrists are in a unique position to advocate for the cultural needs of their patients; they often have more time with patients and have greater opportunity to build rapport. In building rapport with Aboriginal and Torres Strait Islander individuals, psychiatrists should **become privy to the patient's individual connection with community, culture, and Country**. This information, paired with a pre-existing understanding of the socio-political history and context of Australia, a firm grasp on Critical Race Theory, Indigenous Standpoint Theory, and the Cultural Interface and some basic understanding of Traditional Knowledge systems (see above suggestions), should be leveraged to **create a multi-faceted and culturally safe plan that supports the goals and needs of the patient**; such a plan is almost guaranteed to require some Culture Rx.

And finally, at least for this list of actions, **advocate for the involvement of Aboriginal and Torres Strait Islander people in your research, policy writing and medicine in general**. Authentic and meaningful co-design, which is a culturally safe way to work with Aboriginal and Torres Strait Islander peoples, operates across four key domains: Self-Determination, Leadership accountability (Griffiths, 2023) (Appendix 1). Co-design methodology should be employed across psychiatry, but particularly when working in areas that directly affect Aboriginal and Torres Strait Islander people; "Nothing about us, without us".

By including us, Aboriginal and Torres Strait Islander People, in the spaces and stories that have historically excluded or forgotten us, you will be contributing to a much larger effort, that aims to dismantle individual, institutional, and structural racism and achieve health equity. There is still a long way to go, but if most Dickensian works were able to be 500+ pages long, the story of advocating for Aboriginal and Torres Strait Islander peoples within psychiatry might be able to have a few more chapters. As current and future psychiatrists, it is our turn to put pen to paper and live up to our Great Expectations.

Appendix 1. Suggested Framework for Authentic and Meaningful Co-Design (Griffiths, 2023).

First Nations Self Determination	First Nations Leadership and Data Sovereignty	Impact and Value for First Nations Communities	Sustainability and Accountability
<p>Recognises, respects and is responsive to Indigenous ways of knowing, being and doing</p> <p>Meaningful, equitable and authentic partnership, with informed consent</p> <p>Informed consent</p> <p>Cultural safety, responsiveness, and learning</p> <p>Respect and flexibility regarding decision making processes, allowing for innovation and experimentation</p> <p>Shared powered and recognised power differentials</p>	<p>Leadership by Indigenous peoples and researchers</p> <p>Research and responsibilities are jointly owned</p> <p>Evidence of non-Indigenous stakeholders relinquishing power and accepting reciprocity of experience and expertise</p> <p>Emphasis on diversity, inclusivity, and accessibility, with all perspectives involved</p> <p>Special efforts and alternative approaches to ensure seldom and hard to reach groups are represented</p>	<p>Characterised by clear benefit and reciprocity</p> <p>Measures and manages both impact and risk to Indigenous peoples and communities</p> <p>Ongoing dialogue and reflection</p> <p>Opportunities for person and professional development and capacity building</p> <p>Value is measured and reported in meaningful ways</p>	<p>Embeds Indigenous understanding of the holistic natures of health and its interconnectedness with Country</p> <p>Features ongoing First Nations Governance</p> <p>Ground rules are established, transparent and adhered to</p> <p>Opportunities to build on the research and findings for future initiatives</p> <p>Efficacy of co-design methodology is measured and reported in meaningful ways that reflect the experiences of stakeholders</p>

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