Guest Editorial

Engagement of Indigenous Clients in Mental Health Services: what role do cultural differences play?

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Cultural competence, cultural variants, cultural consultants, culture-bound syndromes, traditional treatment hierarchy.

.....that people should suffer from want in a world of excess, that is the greatest shame of all....

Sir Bob Geldolf, 2002, 60 minutes interview.

Research studies on Aboriginal groups in Australia and internationally continue to illustrate the negative impact of colonialisation on their mental health (Australian Institute of Health and Welfare 2002; Australian Institute of Health and Welfare 2003). Despite this, a number of recent articles have argued that Aboriginal people do not access mental health services at a level that is commensurate with this need (Garvey, 2000; Vicary, 2002).

Aboriginal people who come into contact with mental health services are more likely to receive services which are reactive in nature (Atkinson, Bridge et al. 1999; Memmott, Stacy et al. 2000; Westerman 2002c) such as basic counselling, advocacy, support or diversionary activities. In combination, this means a dearth of preventative or therapeutic levels of intervention with Aboriginal people, despite the obvious need for this. Contributing to this problem is that there exist few published examples of effective preventative programs or therapeutic interventions with Aboriginal people. Whilst examples of good practice exist, this information is not being shared within the profession, therefore not providing an opportunity for empirical and cultural validation or replication across different contexts. This has affected service delivery at the individual clinical level as well as at the broader system levels, the combined effect being the inequity in access to mental health services by Aboriginal people.

Problems at the clinical level include that practitioners often have the desire to be 'culturally appropriate', but are frustrated by the lack of empirically grounded conceptual frameworks that have proven their efficacy with Aboriginal people with specific mental health issues Successful outcome is mostly measured subjectively and in the absence of a consistent theoretical framework which can be applied to specific presenting issues. This again makes tracking successful outcome attributable to intervention difficult.

At the system level, services struggle with embedding / incorporating culturally appropriate practice within policy and procedural frameworks. Given that models of service delivery have been characteristically monocultural, significant onus is left to services to determine solutions in the absence of guidance. This is also done in significant absence of outcome driven evaluative processes which convince organisations of the 'fiscal' sense of adopting certain practices (Swan and Raphael 1995; National Aboriginal and Torres Strait Islander Health Council 2002; Westerman 2002).

The solution to increasing access to mental health services by Aboriginal people lies in the integration of specific cultural and clinical

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competencies within the system and practitioner levels. Clinical competence is often defined as the extent to which certain therapeutic techniques are proven to be useful treatments for certain disorders (Raphael 1992; Spence 1994; National Health Priority Areas 1998). Cultural competence is the about the ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in mental illness (Cross, Bazron et al. 1989; Cuellar and Paniagua 2000; Dana 2000).

Increasing Cultural Competence in Services

There is abundant research evidence that the development of guidelines, which aim to increase the cultural competence of clinicians, increases service utilisation and promotes beneficial outcomes for Aboriginal clients (Dana 1998; Vicary and Andrews 2001; Westerman 2001; Vicary 2002). Dana (2000) has defined the components of cultural competence as eleven different counselling competencies. These have been organised under cultural awareness and beliefs, cultural knowledge, and flexibility (Dana 1998; Dana 2000). Cross, Bazron, Dennis & Issacs (1989) have developed a Cultural Competence Continuum for practitioners to increase their level of competence in working with minority populations. This continuum has been used to design training programs, and improve the self-awareness of clinicians regarding their strengths and deficits in working with minority populations. The continuum has been validated for use with services and practitioners in Western Australia (see Westerman, 2003).

Engaging Aboriginal People in Mental Health Services

The engagement of Aboriginal people in mental health services has traditionally been fraught with difficulty. Research indicates that not only are Aboriginal people less likely than their NA[1] counterparts to engage in mental health services, they are also likely to engage at a more chronic level, and for shorter periods of time (McKendrick, Cutter et al. 1992; Vicary and Andrews 2001). A number of research papers have attempted to provide explanations for this (McKendrick, Thorpe et al. 1990; Dudgeon 2000; Garvey 2000). Primarily the basis of these explanations has been the 'cultural inappropriateness' of existing services, or the failure of mental health services and clinicians to embrace Aboriginal conceptualisations of health and well-being (Dudgeon 2000). However, few attempts have been made to define or fully operationalise the basis of cultural inappropriateness, or provide methods by which clinicians are able to adapt their practice appropriately. The range of problems that have been identified (see Westerman, 2003) as impacting on the engagement of Aboriginal people in mental health services have been narrowed down to two constructs; (A) the cultural appropriateness of the processes used by practitioners when engaging Aboriginal people and, (B) qualities intrinsic to the practitioner – client relationship. These will now be discussed and some solutions generated (C) to address these issues.

A. THE USE OF INAPPROPRIATE PROCESS TO ENGAGE ABORIGINAL PEOPLE

1. Appropriateness of Introductions

Introductions between Aboriginal client and practitioner should incorporate understandings that Aboriginal people relate to land, country and genealogy. Clinicians should be comfortable discussing relationships and connections to land with Aboriginal people. NA practitioners should also have an understanding of different language and family groups within the region in which they work. It is therefore essential to have a sound knowledge of family groups, tribal boundaries and skin groups to ensure effective engagement.

2. Assessing Aboriginal people outside of cultural context

There are many examples of misdiagnosis, under-diagnosis and over-diagnosis occurring with Aboriginal people as a direct result of being assessed outside of their country / community, or preferred cultural context (Hunter, 1988; Westerman, 2003). Hunter (1988) for example noted that Aboriginal people assessed in foreign and sterile

[1] The acronym NA will be used to refer to Non-Aboriginal

environments would present as significantly more distressed than usual. This means that practitioners need to ensure that the assessments they have conduct 'match' how Aboriginal people are viewed within their culture. This has two elements. First, whether the symptoms are evident across both mainstream and cultural contexts, and second, whether these symptoms impair the individual within both of these environments.

3. Failure to acknowledge mental health as holistic

It is generally accepted that Aboriginal culture is holistically based (Clarke and Fewquandie 1996). In definitional terms, this means that concepts of mental ill health for Aboriginal people will always need to take into account the entirety of one's experiences, including physical, mental, emotional, spiritual and obviously, cultural states of being. In more practical terms, this means that health may not be recognised in terms of a mind / body dichotomy (Slattery 1994). This effectively makes the western model of ascribing illness to disease inappropriate or irrelevant to the beliefs of most Aboriginal people. It is not uncommon for example, for Aboriginal people to speak of *being unwell within themselves* or feeling that *things are not quite right*, without necessarily translating this to physical signs or mood states (Roe 2000). This is in obvious contrast to westernised views of mental health in which people are more likely to ascribe feeling unwell to a specific symptom (e.g., Being depressed; anxious).

In addition, serious sickness, including mental health is often attributed to *external forces or reasons*. Research that has occurred within this area argues that Aboriginal people have an *external attribution belief system* that is associated with any experiences of ill health (Reid and Trompf 1991). In effect, when ill health occurs, individuals will most likely attribute this to some external wrongdoing which is most likely to be culturally based. For example, "doing something wrong culturally", or "being paid back" for wrongdoing are common attributions made to mental health conditions (Westerman 2000; Sheldon 2001; Vicary and Andrews 2001). This reflects the intertwining of spirituality and particularly relationships with family, land and culture (Slattery 1994).

4. The use of cultural consultants

The use of cultural consultants should become standard practice throughout mental health services working with Aboriginal people. In fact, Vicary (2002) found that ninety two percent of Aboriginal people in his study stated they would not see a NA practitioner unless another Aboriginal person (cultural consultant) had vouched for them as appropriate. 'Vouching' means that members of the Aboriginal community would convey positive or negative information about the therapist to potential clients.

Practitioners often engaged cultural consultants in ways that were culturally inappropriate. These factors included; (a) engaging the wrong level of cultural consultant for the presenting problem; (b) engaging a cultural consultant of the opposite gender to the client; (c) engaging a cultural consultant who had an avoidance relationship with the client; (d) engaging a cultural consultant from a different tribal or language group to the client and who did not have an understanding of each other's culture, and; (e) engaging a cultural consultant who was feuding with the client's family.

Added to these concerns is the fact that Aboriginal people who were approached to be cultural consultants would not necessarily volunteer information of a cultural nature that precluded them from being engaged as cultural consultants. Solutions to the effective engagement of cultural consultants include; (i) practitioners must ask the question "Is there any cultural reason why you can't be involved?" (ii) practitioners were culturally knowledgeable and competent; (iii) the client nominated the cultural consultant, and (iv) the community validated this choice or 'vouched' for the person as appropriate.

5. Putting people on the 'spot' for a direct answer

Communication styles differ within Aboriginal communities compared to non-Aboriginal communities. Questions that focus on the narrative, which are open-ended and positively phrased are therefore consistently cited as the

most effective approaches (Kearins 1976; Harris 1977; Malin 1997). Additionally Malin (1997) discusses how the level of "shame" felt by Aboriginal people who are spotlighted to provide a direct answer to a direct question can be such that any response, whether it is correct or not, is often provided simply to take them out of the spotlight.

(B) Qualities intrinsic to the practitioner – client relationship

1. Cultural disparity between client and practitioner

A major contributor to the lack of engagement of Aboriginal people in mental health services has been identified as the extent of cultural differences between client and practitioner (Kearins 1981). Often the greater the extent of cultural differences, the less likelihood of effective engagement.

2. Gender Differences between client and practitioner

Aboriginal people are generally raised to relate closely to people of the same gender (Kearins 1976; Harris 1977; Kearins 1981; Davidson 1988). This means that boys and girls are often separated from each other at an early age and encouraged to interact closely with those of the same gender. As a result, it is often inappropriate for mental health practitioners to work with Aboriginal people of the opposite gender. This is often the result of the "shame" felt by people to engage in intimate discussions with people of the opposite gender.

(C) Some solutions and considerations

1. The Use of Culturally Appropriate Counselling Techniques

Some authors have discussed the use of culturally appropriate techniques and strategies for non-Aboriginal practitioners to use in working with Aboriginal people and communities (Slattery 1994; Vicary 2002). Some of these writers have noted that Aboriginal culture and conceptualisations of mental health differ markedly from western beliefs (Sykes 1978; Dudgeon, Grogan et al. 1993; Seru 1994) and have suggested an array of generic, culturally appropriate methodologies to assist workers in the field. There exists a limited base of specialist therapeutic interventions, which are steeped in conceptual, evidence-based treatment models (Vicary and Andrews 2001; Vicary 2002). Roe (2000), has also described a culturally derived model of intervention that is based on the spirit, or as he refers to it, the Ngarlu or lian.

Vicary (2002), has developed a model of therapeutic intervention for practitioners to work more effectively with Aboriginal clients. He focuses on ten distinct stages of intervention, the first four being concerned with effective engagement or therapeutic alliance between the NA practitioner and Aboriginal client. These stages are linked primarily to having attained a high level of cultural awareness through researching local Aboriginal culture, customs, taboos, and language. Vicary also considers that understanding and appreciating the historical context of Aboriginal people is an essential component of this process. Finally, Vicary considers ongoing cultural supervision is essential for NA practitioners to attain cultural competence.

2. Cultural supervision

All clinicians working with Aboriginal clients should have access to ongoing cultural supervision. This process is similar to that of the cultural consultant however, the process is more formalised and based upon particular cultural competencies. Additionally, clinicians are required to conduct regular self-assessment regarding their particular competencies in specific learning areas. This is overseen by a senior clinician in a co-operative relationship with a cultural teacher of some standing within the local community (Casey 2000; Westerman 2003).

3. Developing information regarding culture specific mental health problems – culture-bound syndromes

A study by Westerman (2003) resulted in the validation of a range of disorders, which exist uniquely within the Aboriginal community. These illnesses termed 'culture-bound disorders' (American Psychiatric Association 1994) often mimic mental health disorders, however, the triggers and maintaining factors lie within the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level. Whilst there is a fairly extensive volume of research on existence culture-bound syndromes within Indigenous populations around the world, this research represents the first attempt to validate the existence of these disorders for Aboriginal Australians.

4. Incorporating culturally appropriate treatment options within interventions

There is a need to acknowledge existing frameworks of healing within Aboriginal communities and in particular those pertaining to the resolution of culture-bound disorders. This should be conducted via the following methods;

1. Offering Aboriginal clients the option of traditional methods of healing as a primary treatment.
2. Recognising and respecting the traditional processes that exist for Aboriginal people to resolve mental health problems. This has been referred to by Vicary (2002) as the "Traditional Hierarchy of Treatment for Aboriginal Clients", which will be explained further in the next section.
3. Facilitating traditional methods of healing through engaging with traditional healers and cultural consultants (at an appropriate level).

Recent research indicates that a primary barrier to engagement in mental health services for Aboriginal people lies in the failure of services to acknowledge and be able to work within traditional methods of resolving mental health problems (Casey 2000; Westerman 2001; Vicary 2002; Westerman 2002c) as already discussed.

5. The hierarchical structure of Aboriginal problem resolution: implications for treatment and intervention

The anthropological examination of the Aboriginal culture has led to the depiction of the Aboriginal culture as hierarchical (Tonkinson 1976; Vicary and Andrews 2001). In line with this, Vicary found that Aboriginal people in the Kimberley and Perth, Western Australia had a consistent process of traditional treatments that they would explore within their communities when someone became unwell mentally. This process would involve traditional healers, elders and other members of the community who were seen as having a role in healing, advocacy, support or transgressions related to culture and particularly men's business. It is therefore vital for practitioners to have a good conceptual understanding of the traditional hierarchy of treatment interventions (see Vicary, 2002).

6. Operating outreach

A number of papers (Dudgeon, Grogan et al. 1993; Vicary and Andrews 2001; Westerman 2002) have highlighted the need for mainstream services to operate an outreach capacity where possible, based upon the expression of this need by the Aboriginal community. Additionally, Vicary (2002) argues that Aboriginal people are more likely to engage with practitioners who are highly visible in communities as this provides the opportunity for Aboriginal people to determine the appropriateness of the practitioner through being able to see and judge them. This often occurs through a spiritual dimension – that is, a sen(Casey 2000)se of the person's strength and goodness of spirit is often the basis under which engagement will occur. Additionally, it allays some of the stigma that Aboriginal may feel when accessing a mental health service. It also importantly, matches the strong sense of spirituality that Aboriginal people have within themselves and are able to see in others.

7. Referral Processes of Services

Contact between Aboriginal people and mental health services most often occurs in an indirect manner (Vicary 2002). As such, referrals may need to be accepted on behalf of a significant family or community member. Further research into this vexing issue is needed to enable services to develop appropriate guidelines around the referral process.

Summary

To increase the levels of access by Aboriginal people to mental health services, changes must occur to service delivery at the practitioner and system levels. The focus of this change should be to embed elements of cultural and clinical competence within practice. This has often proved elusive, not the least because there is a lack of direction from within the research regarding at which point along the assessment process culture needs to be taken into account. Information regarding what constitutes culturally appropriate practice is also not forthcoming. For services to ensure ongoing and effective changes in the extent of cultural competence, they must ultimately aim to have minimal standards of cultural competence that must be attained by all staff who work directly with Aboriginal people. Ensure that practitioners have ongoing access to cultural supervision to increase cultural competence is also necessary (see Vicary, 2002 for a review), and that this incorporate a monitoring procedure such as a cultural competence continuum (Westerman, 2003). Finally, services must also be able to use a range of appropriate cultural consultants in their service which reflect the complexity of the presenting problem and validate the central role that culture can often play in assessment and treatment.

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