



## 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*

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### Introduction

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

(Sir Bob Geldof, 2002, 60 Minutes interview)

Research studies on Indigenous groups in Australia and internationally continue to illustrate the negative impact of colonisation on their mental health (Australian Institute of Health and Welfare, 2002, 2003). Despite this, a number of recent articles have argued that Indigenous people do not access mental health services at a level that is commensurate with this need (Dudgeon, Grogan et al., 1993; Garvey, 2000).

Indigenous people who come into contact with mental health services are more likely to receive services which are reactive in nature (Atkinson & Clarke, 1997; Memmott, Stacy, Chambers & Keys, 2000) such as basic counselling, advocacy, support or diversionary activities. In combination, this means a dearth of preventative or therapeutic levels of intervention with Indigenous 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 Indigenous 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 Indigenous 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 Indigenous 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

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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.

The solution to increasing access to mental health services by Indigenous people lies in the integration of specific cultural and clinical 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 (National Aboriginal and Torres Strait Islander Health Council, 2003). Cultural competence is 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, 1995; 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 Indigenous clients (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 (Cross, Bazron, Dennis & Issacs, 1989). Cross, et al., (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 Indigenous people in mental health services**

The engagement of Indigenous people in mental health services has traditionally been fraught with difficulty. Research indicates that not only are Indigenous people less likely than their non-Indigenous 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 & Thorpe, 1994; Vicary, 2002). A number of research papers have attempted to provide explanations for this. 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 Indigenous conceptualisations of health and well-being (Dudgeon, 2000; Garvey, 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 Indigenous people in mental health services have been narrowed down to two constructs: (a) the cultural appropriateness of the processes used by practitioners when engaging Indigenous people and (b) qualities intrinsic to the practitioner-client relationship. These will now be discussed and some solutions generated to address these issues.

#### **a. The use of inappropriate process to engage Indigenous people**

##### *Appropriateness of introductions*

Introductions between Indigenous client and practitioner should incorporate understandings that Indigenous people relate to land, country and genealogy. Clinicians should be comfortable discussing relationships and connections to land with Indigenous people. Non-Indigenous 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.

##### *Assessing Indigenous people outside of cultural context*

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

environments would present as significantly more distressed than usual. This means that practitioners need to ensure that the assessments they have conducted ‘match’ how Indigenous 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.

### ***Failure to acknowledge mental health as holistic***

It is generally accepted that Indigenous culture is holistically based (Clarke & Fewquandie, 1996). In definitional terms, this means that concepts of mental ill health for Indigenous 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 Indigenous people. It is not uncommon for example, for Indigenous 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 Indigenous people have an *external attribution belief system* that is associated with any experiences of ill health (Reid & 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 (Sheldon, 2001; Westerman, 2003). This reflects the intertwining of spirituality and particularly relationships with family, land and culture (Slattery, 1994).

### ***The use of cultural consultants***

The use of cultural consultants should become standard practice throughout mental health services working with Indigenous people. In fact, Vicary (2002) found that ninety two percent of Indigenous people in his study stated they would not see a non-Indigenous practitioner unless another Indigenous person (cultural consultant) had vouched for them as appropriate. ‘Vouching’ means that members of the Indigenous 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 Indigenous 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 included: (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.

### ***Putting people on the ‘spot’ for a direct answer***

Communication styles differ within Indigenous communities compared to non-Indigenous communities. Questions that focus on the narrative, which are open-ended and positively phrased are therefore consistently cited as the most effective approaches (Harris, 1977; Malin, 1997). Additionally Malin (1997) discusses how the level of ‘shame’ felt by Indigenous 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**

### ***Cultural disparity between client and practitioner***

A major contributor to the lack of engagement of Indigenous 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.

### ***Gender differences between client and practitioner***

Indigenous people are generally raised to relate closely to people of the same gender (Harris, 1977). 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 Indigenous 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.

## **Some solutions and considerations**

### ***The use of culturally appropriate counselling techniques***

Some authors have discussed the use of culturally appropriate techniques and strategies for non-Indigenous practitioners to use in working with Indigenous people and communities (Slattery, 1994; Vicary, 2002). Some of these writers have noted that Indigenous culture and conceptualisations of mental health differ markedly from western beliefs (Seru, 1994; Sykes, 1978) 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 & 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 Indigenous clients. He focuses on ten distinct stages of intervention, the first four being concerned with effective engagement or therapeutic alliance between the non-Indigenous practitioner and Indigenous client. These stages are linked primarily to having attained a high level of cultural awareness through researching local Indigenous culture, customs, taboos, and language. Vicary also considers that understanding and appreciating the historical context of Indigenous people is an essential component of this process. Finally, Vicary considers ongoing cultural supervision is essential for Non-Indigenous practitioners to attain cultural competence.

### ***Cultural supervision***

All clinicians working with Indigenous 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).

### ***Developing information regarding culture specific mental health problems – culture-bound syndromes***

Research by Westerman (2003) resulted in the validation of a range of disorders, which exist uniquely within the Indigenous 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 the existence of culture-bound syndromes within Indigenous populations around the world, this research represents the first attempt to validate the existence of these disorders for Indigenous Australians.

### ***Incorporating culturally appropriate treatment options within interventions***

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

1. Offering Indigenous clients the option of traditional methods of healing as a primary treatment.
2. Recognising and respecting the traditional processes that exist for Indigenous people to resolve mental health problems. This has been referred to by Vicary (2002) as the 'Traditional Hierarchy of Treatment for Indigenous 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 Indigenous people lies in the failure of services to acknowledge and be able to work within traditional methods of resolving mental health problems (Casey, 2000; Dudgeon et al., 1993) as already discussed.

### ***The hierarchical structure of Indigenous problem resolution: implications for treatment and intervention***

The anthropological examination of the Indigenous culture has led to the depiction of the Indigenous culture as hierarchical (Tonkinson, 1974). In line with this, Vicary (2002) found that Indigenous 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).

### ***Operating outreach***

A number of papers (Dudgeon et al., 1993; Westerman, 2002, 2003) have highlighted the need for mainstream services to operate an outreach capacity where possible, based upon the expression of this need by the Indigenous community. Additionally, Vicary (2002) argues that Indigenous people are more likely to engage with practitioners who are highly visible in communities as this provides the opportunity for Indigenous 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 sense of the person's strength and goodness of spirit is often the basis upon which engagement will occur. Additionally, it allays some of the stigma that Indigenous people may feel when accessing a mental health service. It also, importantly, matches the strong sense of spirituality that Indigenous people have within themselves and are able to see in others.

### ***Referral processes of services***

Contact between Indigenous 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 Indigenous 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 Indigenous people. Services must ensure that practitioners have

ongoing access to cultural supervision to increase cultural competence (see Vicary, 2002 for a review) and that this incorporates 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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