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Engaging Indigenous People in Mental Health Services in Australia

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The engagement of Indigenous Australians in mental health services is an important, current issue which, as yet, has not been addressed effectively in a widespread or sustainable way. While effective initiatives can be identified from time to time, these tend to be isolated efforts situated against mainstream policies and practices, which, for the most part, endorse a Western biomedical approach to mental health that is not always relevant, appropriate, or helpful for Indigenous Australians. In this chapter, we use the term 'Indigenous Australians' to refer to both Aboriginal and/or Torres Strait Islander Australians.

We begin this chapter by examining the historical context of current Indigenous Australian mental health status, concentrating on events after European settlement. Appreciation of the impact of the colonising process over the last 200 years is central to comprehending the complex, contemporary mental health consequences on those so colonised, as well as developing

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an appropriately conceptualised, nuanced praxis with which to respond effica-ciously. After providing some historical information, we outline details about the present status of Indigenous Australians from a health perspective, includ-ing mental health.

The health status of Indigenous Australians lags unacceptably behind that of other Australians on almost any indicator chosen. Part of the problem in the area of mental health may be that mental health is construed differently, both conceptually and practically, for Indigenous Australians compared to non-Indigenous Australians, yet many of our mental health services have still not recognised this or adapted to it. Where the perceived utility, cultural con-sonance, or personal acceptability of the mode and manner of care on offer is deemed to be lacking, the uptake of that service will be constrained. By detailing both the current health status of Indigenous Australians and the social determinants of health contributing to that status, we intend to convey that improving service engagement by Indigenous Australians involves not just the provision of services but also ensuring that access to these services is, in fact, realised.

In a general sense, the current provision of mental health services for Indigenous Australians is both inappropriate and inadequate (Dudgeon et al. 2014; Westerman 2010). While there is a lack of reliable studies in the area of Australian Indigenous mental health and social and emotional well-being, the available evidence indicates that there is a pronounced separation between the mental health status of Indigenous and non-Indigenous Australians, and this disparity is increasing in some areas (Dudgeon et al. 2014). There is an urgent need, therefore, to find effective and sustainable solutions.

The final section of the chapter discusses some of the implications for mental health services in respecting and reflecting Indigenous Australians' understanding of mental health, as well as some guidelines for making services more meaningful from Indigenous perspectives. Ironically, mak-ing mental health services more engaging and effective for Indigenous Australians may also make these services more effective for many non-Indigenous Australians. Frequently, non-Indigenous Australians still do not appreciate how much they can learn from Indigenous Australians, and this chapter is a contribution to correcting this situation so that all Australians can enjoy robust states of mind and live satisfying, meaning-ful lives. The argument we are presenting here, of the non-immutability of Western concepts of mental health, can be situated within a broader debate in which the framework of Global Mental Health itself is questioned (Summerfield 2013).

The Historical Context of Indigenous Australians' Mental Health and Well-Being

It is estimated that Indigenous people had lived in what was to become known as Australia for between 40,000 and 60,000 years prior to European colonisation. During this time, there were more than 250 different language groups, reflecting a diversity of cultures across the continent. The peoples of this land suffered from few diseases compared with Europeans. While Europeans had to contend with health problems such as smallpox, measles, influenza, tuberculosis, scarlet fever, venereal syphilis, and gonorrhoea, these were unknown to Indigenous Australians (Macrae et al. 2013). Also, Indigenous Australians had a sophisticated system of land management to the extent that wildlife and plant foods were generally plentiful throughout the year and the landscape had a park—or estate—like quality to it (Gammage 2011).[1]

After European contact, introduced diseases were a major cause of death for Indigenous people, and conflicts stemming from the European occupation of Indigenous homelands made substantial contributions to Indigenous mortality (Macrae et al. 2013; Reynolds 2013). Before colonisation, Indigenous people were free to determine for themselves the ways in which their lives would unfold. Once Europeans began to spread across the country, however, Indigenous people's capacity for healthy living was compromised through the disruption of relationships, the dispossession of land, the elimination of traditional foods, and a general devaluing of cultures (Macrae et al. 2013). The general loss of autonomy initiated a cycle of dispossession, demoralisation, and poor health that has continued to the present day (Macrae et al. 2013). The phenomenon has been dubbed 'historic' (Duran and Duran 2005) or 'collective' trauma (Atkinson 1997; Krieg 2009), although Kirmayer and colleagues have cautioned against a presumption of any automaticity of simple intergenerational transmission, arguing that contemporary 'structural violence' must be factored in—and may possibly be more corrosive of Indigenous well-being (Kirmayer et al. 2014, p. 313). The maintenance, or re-vitalisation, of culture has been connected to resilience in the face of colonisation's destructive effect on well-being (Kirmayer et al. 2003). Resilience,

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[1] The term 'estate' should not imply European notions of land sequestration for the benefit of the fortunate few. It, rather, conveys the alternative reading of 'well-managed land', which was worked to provide the resources needed by the whole group through such means as: 'fire-stick farming'; sustainable, strictly-seasonal food-gathering; and intricate riverbed fish traps. Incoming colonial authorities did not recognise such unfamiliar 'management'—an important precursor to dispossession and the legal fiction of Terra Nullius: 'land belonging to no one'.

however, may be undermined by the widespread erosion of the opportunity to conduct everyday Indigenous lives framed within Indigenous cultures. Most Indigenous Australian languages, for example, have already vanished, and it has been estimated that these languages are dying at the rate of one or more per year (Nettle and Romaine 2000).

The effects of colonisation on well-being are profound. Awareness of Indigenous Australians' lack of resistance to disease at colonisation is widely known; however, the widespread and long-lasting occurrence of violent frontier conflict is much less recognised. The historian Henry Reynolds now terms it the 'Forgotten War' (Reynolds 2013). Apart from such direct impacts of colonial expansion (and the resultant depopulation and trans-generational trauma), the imposition of colonial authority—delivered through both formal policies and widespread informal practices, jointly dubbed 'Clayton's apartheid'[2] (McDermott 2004)—has contributed powerfully, though less obviously, to contemporary Indigenous mental distress (Commonwealth of Australia 1997; McDermott et al. 2008). Particularly pertinent was the emergence of a suite of mechanisms fostering widespread, sustained practices of forcible child removal—most commonly referred to, in both Indigenous and non-Indigenous Australian parlance, as the 'stolen generations'. By the late nineteenth century, the population of Australian people who were solely of Indigenous descent was declining, yet that of Indigenous Australians with also European, Afghan, Chinese, or other ancestry was increasing (Commonwealth of Australia 1997). Government officials reasoned that if Indigenous children were forcibly removed from their families and sent away from their communities to live in group homes, or work for non-Indigenous people, then, over time, the mixed-descent population would 'merge' with the non-Indigenous population (Commonwealth of Australia 1997). 'Merging' eventually became 'assimilation', with the introduction of legislation under the pretext of child welfare.

It is estimated that, from 1910 to 1970, between one in three and one in ten Indigenous children were forcibly removed from their families and communities (Commonwealth of Australia 1997). The effects of these removal practices cannot be overstated. Removal affected the removed children, as well as parents, siblings, family groups, and communities. The *National Inquiry into the Separation of Aboriginal and Torres Strait Islander children from*

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[2] 'Clayton's' ('virtual' or 'de facto') apartheid takes its cue from ironic Australian vernacular usage of the non-alcoholic, scotch lookalike, Clayton's (Kola) Tonic. The long-running advertising catchphrase was: 'The drink you're having when you're not having a drink'.

their families (often referred to as the *Bringing Them Home Report*) was told repeatedly about the damage to children who were removed, and the effects on subsequent generations whose parents and grandparents were forcibly removed, who had their Indigeneity demeaned, and who were often otherwise traumatised and abused (Commonwealth of Australia 1997).

The importance of attending to the potential role that trauma plays in the emergence of complex mental health problems has been highlighted. For example, Morrison et al. (2005) highlighted the association between trauma and psychosis. Internationally, moves for a fresh focus on the role of trauma in mental health and well-being have paralleled by those arising from research with Indigenous Australians (Atkinson 2002). This has in turn led to calls for trauma-informed services, offering trauma-specific care, at least for Indigenous Australian children (Atkinson 2013). Given this emphasis, the population-level 'trauma history' undertaken in this chapter offers a way to better comprehend a number of historically generated social determinants of Indigenous Australian mental health, as well as how they might interact with a range of contemporary determinants. We posit that, in the Indigenous Australian context, the deliberative manner, widespread scale, and trans-generational impact of forcible child removal requires consideration, and response, as a social determinant in its own right. In recognition of the complex interaction of the past and the present, one of this chapter's authors (DRMcD) has proposed a schema (see Fig. 27.1, below) to facilitate comprehension of the dynamic constitution of Indigenous mental distress, which can be seen as:
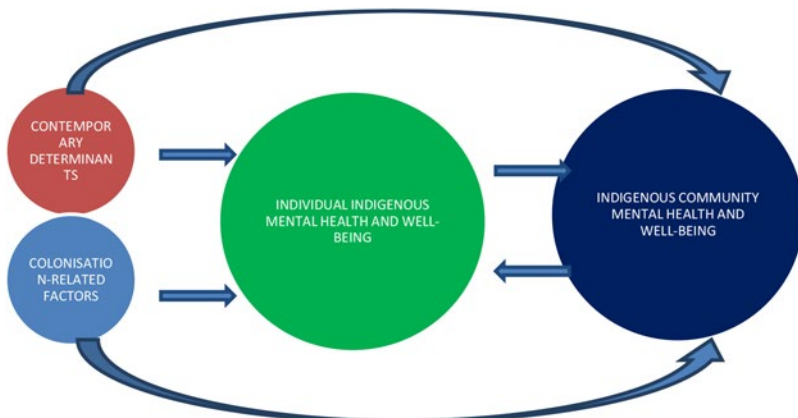
Fig. 27.1 Interacting dimensions of Indigenous Australian mental health and well-being

[a] core of colonisation-related factors, surrounded by a range of contemporary determinants, all mediated by a variable exposure to trans-generational trauma. Racism, thus [for example], may oxygenate 'historic' or 'collective' trauma. (McDermott 2008, p. 22)

Figure 27.1 depicts individual Indigenous mental health as 'nested' within wider Indigenous community well-being. Contemporary social determinants have impact at both an individual and community level, as do the contemporary consequences of colonisation-related factors at the 'core' of the schema. After Krieg's (2009) and Atkinson's (1997) extension of the notion of 'collective' trauma to the Indigenous Australian context, the model also allows that the sequelae of such trauma, while operating at the community level, also flow back to the individual person. As Krieg notes, drawing on an earlier application of the notion to communities' post-natural disaster:

Collective trauma allows us to acknowledge traumatized communities as something more than assemblies of traumatized persons and it can do so without unduly pathologizing feelings, behaviours or individuals. (Krieg 2009 p. S30)

The Current Context

According to the 2011 census, Indigenous Australians comprise approximately 3% of the total Australian population (Australian Indigenous HealthInfoNet 2013). Indigenous women have more babies (2.7 on average compared with 1.9 for non-Indigenous Australian women) and have them at a younger age than non-Indigenous Australian women (Australian Indigenous HealthInfoNet 2013). The infant mortality rate is also higher for Indigenous babies compared with non-Indigenous babies (Australian Bureau of Statistics 2013). The life expectancy for Indigenous Australians is approximately ten years, or more, less than non-Indigenous Australians (Australian Indigenous HealthInfoNet 2013). Between 2006 and 2010, the leading causes of death for Indigenous Australians were cardiovascular disease (including heart attacks and strokes), cancer, and injury (including transport accidents and self-harm) (Australian Indigenous HealthInfoNet 2013). Diabetes is also a major health problem for Indigenous Australians (Australian Indigenous HealthInfoNet 2013). The contribution to psychological distress of corrosive individual and community levels of grief and loss—arising from early mortality and a heavy burden of morbidity and disability—should not be overlooked (De Maio et al. 2005).

According to the 2008 National Aboriginal and Torres Strait Islander Social Survey, Indigenous compared to non-Indigenous Australians, above

the age of 18, are 2.6 times more likely to experience high or very high levels of psychological distress (Macrae et al. 2013). Also, a significantly greater proportion of Indigenous compared to non-Indigenous Australians reported feeling sad and without hope. Perhaps paradoxically, however, 90% of Indigenous Australians in this survey reported feeling happy either some, most, or all of the time (Macrae et al. 2013). These findings of high levels of psychological distress coupled with a large proportion of people reporting happiness at least some of the time might suggest that concepts such as mental health, psychological distress, and well-being need to be understood, or articulated, differently with Indigenous Australians than they are with non-Indigenous Australians. The findings also imply that the assessment instruments used to collect data on areas such as psychological distress may need to be tailored to remain cognisant of culturally or contextually specific explanations.

Mental Health and Indigenous Australians

The way one defines a particular concept has important implications for the way in which programmes and services might be developed and delivered. This is particularly the case in the area of mental health. If one understands psychological problems according to the nosology described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association 2013), for example, then specialised programmes and services might be developed to treat discrete disorders such as schizophrenia, borderline personality disorder, or generalised anxiety disorder. If, however, a nosology such as the DSM-5 is found to lack validity for classifying distress experienced by particular populations, then the programmes and services traditionally linked to this diagnostic system may prove inappropriate also.

Krieg has noted the 'recurring cycles of unresolved grief and traumatization that have been repeatedly identified by Indigenous peoples as major factors compromising mental health and well-being' and yet, also, described a 'profound mismatch with existing mental health constructions of trauma' (Krieg 2009 p. S30). One of this chapter's authors (DRMcD) has described the developing interest, from an Indigenous perspective, in the assessment of *non-specific mental distress*, noting that:

> Not only are the clarity and aetiology of many specific diagnoses [deemed] questionable but, also, the distress displayed is supra-individual and is tied, inescapably, to colonisation and its sequelae. (McDermott 2008, p. 23)

In Krieg's terms, there may be no one distinct, 'legitimate' traumatic event to be ascertained:

> Colonization was not a moment. It is an ongoing experience with multiple persistent contemporary traumatizing events continuing to impact daily on Aboriginal families and communities. These include the ongoing colonizing practices of social marginalization, incarceration and racism in all its forms, and the retraumatization associated with family violence, sexual abuse, self-harming and substance misuse. (Krieg 2009 p. S30)

Within Indigenous and pan-Indigenous Australian perspectives, then, 'mental health' is a necessary but insufficient premise for organising effective responses. The preferred term for Indigenous Australians is 'social, spiritual, and emotional well-being' (Swan and Raphael 1995). This term recognises the legitimacy of factoring in the social determinants of Indigenous psychological distress and the necessity of incorporating colonisation-related trauma, grief, and loss. The term used by Swan and Raphael (1995), among others, comes from a definition of Indigenous health outlined in the National Aboriginal Health Strategy (NAHS 1989).[3] The definition in the NAHS claims that Indigenous health is:

> Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life. (National Health Strategy Working Party 1989 p. x)

It is important to notice in this definition that a distinction is *not* drawn between physical and mental health. Rather, the functioning of the individual in that individual's cultural, social, and physical context is considered important. Alex Brown and his colleagues have conducted important work in this area demonstrating, among other things, the inextricable link between cardiovascular disease and depression, and that the determinants and expression of depression for Aboriginal[4] men in Central Australia are different from the way

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[3] The National Aboriginal Community Controlled Health Organisation (ACCHO) describes NAHS as being 'built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal health and Torres Strait Islander health'. The Working Party comprised two Commonwealth Government representatives (including an Aboriginal Chairperson), eight State Government representatives, and nine Aboriginal community representatives.

[4] Indigenous Australians employ a large range of self-descriptive terms, which may be applied differentially depending on context and/or preference. The term 'Aboriginal' is used in this context because this is the term that is used in the original study.

depression is characterised for mainstream populations (Blashki and Brown 2005; Brown et al. 2012).

The broadly encompassing notion of ideal day-to-day functioning was conveyed more clearly in the page before the definition offered in the NAHS document. Specifically, it is stated:

Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Prior to colonisation Aboriginal peoples had control over all aspects of their life. They were able to exercise self-determination in its purest form. They were able to determine their 'very-being', the nature of which ensured their psychological fulfilment and incorporated the cultural, social and spiritual sense.

In Aboriginal society there was no word, term or expression for 'health' as it is understood as in Western society. It would be difficult from the Aboriginal perception to conceptualise 'health' as one aspect of life. The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as 'life is health is life'.

In contemporary terms Aboriginal people are more concerned about the 'quality of life'. Traditional Aboriginal social systems include a three-dimensional model that provides a blue-print for living. Such a social system is based on inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between each set of relationships. (National Health Strategy Working Party 1989 p. ix)

The implications of these four paragraphs are profound for the way in which Indigenous mental health might be understood and the way in which services and programmes should be designed (Carey 2013b). It is instructive, for example, that Indigenous Australians did not have a word for 'health' in their languages as it is understood in Western discourse. Also, the importance of control and self-determination are strong themes. Programmes and services, therefore, as well as policies, should pay careful attention to control and the impact their interventions have on the ability of Indigenous Australians to control the things that are important to them (Carey 2013b).

 If more effective services are to be designed, it is important to embrace the difference between Western concepts of mental health and Indigenous Australians' understandings of social, spiritual, and emotional well-being. Throughout the literature, there is evidence of what appear to be attempts to understand the psychological problems of Indigenous Australians through a Western lens. For example, Parker (2010) states that:

> *Notwithstanding the above cultural factors*, psychotic disorders have been reported in a number of cases of the traditional Aboriginal and Torres Strait Islander context. (p. 69, emphasis in italics added)

A propensity to view culture as something that masks or hides the 'real' mental health disorder is a common theme in the literature. Drew et al. (2010) write that:

> Another key feature of mental health concerns is that for Aboriginal people the manifestations of mental disorders can take forms that are unique to their culture and experience. (p. 193)

Here, again, it seems that the Western mental health disorder has assumed a more important status than culture and experience. Sheldon (2010) states the case even more clearly when he claims that:

> Even with the obscuring effects of cultural beliefs (i.e. thought-sharing, hallucinations and possession by spirits), *schizophrenia* and *schizophreniform psychosis* could be identified if there was good corroborative history of grossly disturbed behaviour and the community viewing the person as rama (or local words for 'madness'). (p. 220)

In a discussion about mental health in Indigenous settings, Hunter (2014) makes the point that:

> While there are differences in the prevalence of certain conditions cross-culturally, it is prudent to be guided by the assumption that if it can happen in the mainstream it can also happen in an Aboriginal setting. (p. 26)

This may or may not be true depending on what one's understanding of 'it' is. There is no doubt that humans across the globe have the capacity to experience a variety of emotional states such as elation, despair, misery, contentment, and joy. It is quite another matter, however, to contend that Western

constructs of 'depression' and 'anxiety', for example, apply cross-culturally. There is evidence, for example, that, while depressive symptomatology exists in Australian Indigenous men, it is not characterised by hopelessness as Western depression might be, but, rather, it is characterised by a weakness or injury of the spirit resulting from factors such as a loss of connection to social and cultural life and marginalisation (Brown et al. 2012). As Aboriginal educator, Dr Bob Morgan, rhetorically asked an Indigenous Men's Health Conference audience: 'How do you get cured of spiritual sickness?' (Morgan 1997).

Summerfield (2013) questions how transportable Western mental disorders are to other cultures given that they are grounded in Western culture. He argues:

> It is a lamentable error of epistemology, a category error, to assume that because phenomena can be detected in one setting or another, they mean the same thing everywhere. (p. f3509)

In another jurisdiction—with both colonial parallels and differences, but strongly influenced by Maori-originated notions of cultural safety—the New Zealand Psychologists Board specifically requires of registered psychologists that:

> the psychologist delivering the psychological service will understand and recognise the cultural origins, assumptions and limitations of certain forms of psychological practice within some cultural contexts. (New Zealand Psychologists Board 2014, p. 16)

Reser (1991) suggests that:

> [a]n adequate understanding of psychopathology in other cultures does not exist, and it will be realised only when there is a more widespread and genuine understanding that there exist basic cultural differences with respect to how the world, the self, and distress are experienced and responded to. (p. 221)

Grieves (2009) endorses this view with her extensive review and critique of Aboriginal spirituality. Grieves emphasises that Indigenous Australians' notions of spirituality, as with concepts of health, have no easy translation into English but refer to:

> the basis of our existence and way of life that informs our relationships to the natural world, human society and the universe. (p. 3)

In this chapter, we are not questioning the *possibility* of demarcating Western-style mental health disorders in the behaviour and conduct of Indigenous Australians. We are questioning why anyone would want to. The Indigenous mental health literature provides no clear utility for treatment and outcomes through reliance on Western praxis. The search for clear diagnoses may be quixotic: a real honouring of the complexity of Indigenous mental distress involves re-assessing accepted modes of assessment that are often systemically insisted upon. Haswell-Elkins and her colleagues have noted our 'limited capacity to assess [Indigenous mental disorder] at individual, community and societal levels' (Haswell-Elkins et al. 2007, p. S29). Similarly, Eley and colleagues report on patient and family perceptions of the inappropriate diagnostic and interventional consequences flowing from:

> Major gap[s] in communication between mental health staff and Indigenous patients. (Eley et al. 2006, p. 36)

Given that the current relationship between non-Indigenous and Indigenous Australians reflects a profoundly disturbing coloniser/colonised history, the health system can itself be a hostile, and at times, racist environment. Australian Indigenous psychologist Tracey Westerman (2004), drawing on the work of Hunter (1988), describes a further caveat to an uncritical reliance on supposedly valid Western assessment modes: 'Indigenous people assessed in "foreign or sterile environments" may present as significantly more distressed than usual' (Westerman 2004, pp. 2–3). Westerman also noted:

> many examples of misdiagnosis, under-diagnosis and over-diagnosis occurring with Indigenous people as a direct result of assessment outside of their country/community or preferred cultural context. (Westerman 2004, p. 2)

This Indigenous Australian-specific literature reinforces the wider contention that the Diagnostic and Statistical Manual (DSM) system of classification as advocated by the American Psychiatric Association has no particular scientific legitimacy, and there are increasing calls to abandon it (e.g., Timimi 2011) or to replace it with other systems (e.g., Insel 2013). There is a growing recognition that, even for Western society, the DSM is simply the wrong way to understand psychological functioning (Carey 2013c). Seizing the opportunity, therefore, to learn from Indigenous Australians would almost certainly be beneficial for this group of Australians, but, in all probability, it would also be beneficial for non-Indigenous Australians.

Implications for Engagement in Mental Health Services

In Durie's (1997) term, Western paradigms of 'mental health' suffer from 'conceptual isolation': it is the limited conceptual base that constrains the development of services, assessments, interventions, and even practitioner training that are relevant and effective for Indigenous Australians (Durie 1997; Thorpe and McKendrick 1998). Existing psychiatric diagnoses often provide neither an acceptable fit with Indigenous explanatory models of illness (Gabb and McDermott 2008), nor facilitate an appropriate service response (Swan and Raphael 1995; Brown et al. 2012; McKendrick and Thorpe 1994). Westerman has described usual, 'mainstream' practice as offering a:

> [l]imited base of specialised therapeutic interventions steeped in conceptual, evidence-based treatment models. (Westerman 2004, p. 4)

What is required, rather, is an expanded praxis—an 'Indigenised' praxis—based on a conceptual framework that is holistic in both structure and implementation.

Currently, engagement in services is compromised by bio-medically premised configurations that inadequately address Indigenous preferred responses. Complex presentations are common, with court and justice issues, family violence issues, problematic alcohol and other substance use, child protection questions, and housing insecurity inseparably relevant to any mental distress intervention (Krieg 2006; Cripps 2010; Tilbury 2009).

Two logical consequences of the argument that we have made, thus far, in this chapter are that control and self-determination will be necessary elements of any effective and sustainable solution, as will be the acknowledgement and accommodation of Indigenous perspectives. Endorsing the importance of control and self-regulation will necessarily entail incorporating stakeholder involvement in the design and implementation of mental health services. This point will be returned to later in the chapter.

Control is also fundamental to the social determinants of health with Marmot (2006), reminding us that:

> What is important is not so much what you have but what you can do with what you have. (p. 565)

While the important link between social determinants and physical health is well established, it is also being increasingly recognised that social determinants are just as important to mental health (CSDH 2008).

In order to address the engagement of Indigenous Australians with appropriate services, it is essential, also, to be clear about what is meant by 'engagement'. One approach is to consider mental health services as resources that people can use to make their lives more as they would like them to be, not as programmes or plans that are applied to individuals to shape or mould them in particular ways. There is a connection here between enhancement of the 'control factor', client-centred service configuration, and facilitating resilience—all in the name of better mental distress outcomes. The work of Michael Ungar and colleagues, across a number of international settings, re-positions resilience as something greater than individual 'defiance-of-the-odds'. In the context of exposure to significant adversity, resilience can instead be seen as:

> both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways. (Ungar 2014, n.p.)

Service engagement, from such a perspective, then, begins from a premise of Indigenous Australians being active agents rather than passive recipients of services. It also implies that when services are not being engaged by Indigenous Australians, we should address the service being offered, rather than the person who is currently not taking up the offer. It is important, therefore, to consider engagement from a perspective informed by the needs, desires, and lived reality of the person accessing the service, rather than from the perspectives of the service providers.

Grieves (2009) argues that something much more radical is required than making premises 'Aboriginal-friendly' and providing cultural awareness training for practitioners. A service, for example, that prominently displayed Indigenous artwork and ensured all employees had some cultural awareness training yet still diagnosed and treated mental health problems according to Western standards would be missing the point. Berry and Crowe (2009) endorse this view by suggesting that difficulties with engaging Indigenous clients relate to both limited access to services and a lack of cultural respectfulness of the services. The lack of culturally derived empirical models of practice that are applicable, particularly to Indigenous youth, is cited as another reason for poor engagement with services (Westerman 2010).

In one study, participants perceived that Western-style therapy was culturally inappropriate or irrelevant (Vicary and Bishop 2005). In this study, fear

of the Western mental health system was reported by Indigenous Australians because of the stigma associated with being labelled mentally ill, as well as the possible imposition of certain treatments, such as involuntary hospitalisations and medication. Vicary and Bishop (2005) point to the implications for Indigenous engagement with mental health services in noting that participants in their study:

> actively withheld mentally ill family members from Western services because they were concerned about the possible outcomes. (p. 12)

It is not that fears of stigma and compulsory treatment only bedevil Indigenous Australians: what is noteworthy with respect to Indigenous engagement, rather, is that such fears are compounded by not only historical factors—sometimes generic to the project of colonisation itself, and sometimes specific to the Australian context—but also the impact of a range of contemporary determinants of Indigenous mental health and well-being. Relevant historical factors would include: the past existence of segregated hospital wards; a body of anecdotal (though substantial) evidence of past, forced sterilisations; and the body blow to trust of widespread forcible child removal over many decades—where doctors, hospitals and other health system actors were viewed as active agents in the processes contributing to the 'stolen generations'. Contemporary barriers to resolving the twin impediments of reluctance to engage and early dis-engagement—including even self-discharge, or 'taking own leave', in life-threatening situations, before the completion of the interventions or treatment—revolve around perceptions of a lack of cultural safety in the health service on offer (Einsiedel et al. 2013). Given recent research suggesting that racism in health settings may have a more negative impact than racism in other settings (research that echoes long-standing Indigenous Australian narratives of how health services can make them feel 'sick'), adding the likelihood of encountering racism to concerns about inappropriate modes of health-care delivery may lead to greater risk of dis-engagement (Kelaher et al. 2014).

Any discussion about the importance of perspective, however, would be incomplete without including reference to the unequal power relationship between client and professional—and the way in which this imbalance can inform, or hamper, service delivery. To provide services that Indigenous Australians would want to engage with, it is crucial for service providers to be aware of their own assumptions, attitudes, beliefs, and values. This requires not only fostering health professionals' reflection on their own culture in relation to therapeutic interactions but, also, the re-positioning of such reflective practice as the default setting for effective cross-cultural work, that is, as *core* clinical, health promotional, and organisational business. One exemplar

approach which encapsulates the need for the mitigation of power differentials—for the development and embedding of self-reflective practice, and for treating clients 'regard-ful', rather than regardless, of difference—is the earlier mentioned approach of cultural safety.

The same precepts of recognising and reducing power differentials, self-reflexivity, and conscious avoidance of a conflation of equity and sameness of treatment (often expressed as 'I just treat everyone the same') are central to a number of other approaches that are of similar pertinence to facilitating better Indigenous Australian engagement in mental health services. These include: cultural humility (Tervalon and Murray-Garcia 1998); the more nuanced and flexible models of cultural competence offered by Weaver (1999) (a model from a Native American perspective) and Goode and colleagues at the (US) National Center for Cultural Competence (Goode 2014); and the Australian-developed Integrated Model of Gabb and McDermott (2008). These approaches inform our comprehension of the minimum good practice requirements for effective cross-cultural service provision, yet their implementation holds major ramifications for individual practitioner training, organisational quality assurance, and overall service configuration.

At a pragmatic level, effective solutions will often be locally developed, and must be adequately staffed with appropriate funding models (Carey 2013a). Evaluation should be an ongoing and an inherent part of any programme with local knowledge and expertise being integral to the service (Carey 2013a). Issues of recruitment will be nuanced, so that it may be necessary to reconsider conventional employment position descriptions in order to employ the most appropriate staff. Early and ongoing community consultation will be an important facet of the continuity of the programme in order to ensure that the service being provided remains relevant to the needs of the community. Even the structure of interventions should be considered to avoid conflict with Indigenous communities' concepts of time, relationships and obligations, and the 'rhythm' of community life (Robinson and Tyler 2008). These may include not only culturally significant seasonal ceremonies but, also, the need to halt business as usual, upon a community death—sometimes for extended periods—for the conduct of 'sorry business'.

Good Practice Guidelines and Examples

Dudgeon et al. (2014) outline nine guiding principles, and they suggest that services that reflect these principles are more likely to be effective than those that do not. The principles were first articulated by Swan and Raphael (1995) and were

adopted as the foundation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (Social Health Reference Group 2004). The nine principles are:

1. health as holistic, encompassing mental, physical, cultural, and spiritual health;
2. the right to self-determination;
3. the need for cultural understanding;
4. recognition that the experiences of trauma and loss have intergenerational effects;
5. recognition and respect of human rights;
6. recognition that racism, stigma, environmental adversity, and social disadvantage have negative impacts;
7. recognition of the centrality of family and kinship and the bonds of reciprocal affection, responsibility, and sharing;
8. recognition of individual and community cultural diversity; and
9. recognition of Indigenous strengths (Social Health Reference Group 2004, p. 6).

Services will more effectively engage, and offer scope for more effective outcomes, to the extent that Indigenous Australians are able to recognise these principles within the service.

Dudgeon et al. (2014) conducted a literature review of the academic and 'grey' literature to identify effective services. They located 49 studies describing 42 programmes or initiatives that provided information about service effectiveness in addressing a social and emotional well-being outcome for Indigenous Australians. From their review they developed several themes to enhance mental health programme and service delivery success:

- Indigenous participation in the design and delivery and evaluation of programmes;
- Working collaboratively with Indigenous services and the community;
- Initiating programmes to commit to being (and to demonstrate that they are) culturally appropriate, competent, and respectful of Indigenous culture;
- Having a strong capacity-building focus where knowledge, resources, and skills are shared and developed and Indigenous experience and knowledge are recognised;
- Working together with other (mainstream and Indigenous) services to support the delivery of a holistic and integrated programme or service;
- Fostering a culturally safe environment for programme participants;

- Flexibility—having structures and components that cater to local need;
- Enhancing existing services and resources to enable programme continuity; and
- Taking account of gender, family and kinship systems, language groups, and the involvement of community Elders in programme development and delivery (Dudgeon et al. 2014, p. 24).

Ensuring that mental health services reflect the principles and themes highlighted by Dudgeon et al. (2014) will be an important step for health service planners and service providers to take in order to improve the acceptability and effectiveness of services for Indigenous Australians. It is possible that adopting these themes and principles would also improve services for non-Indigenous Australians.

These principles and themes are complemented by other information, such as that provided by the Australian Indigenous HealthInfoNet (2014), regarding the way in which health services generally can be made more accessible for Indigenous Australians. The Indigenous HealthInfoNet suggests:

- Having Indigenous health workers on staff;
- Increasing the number of Indigenous people working in the health sector (doctors, dentists, nurses, etc.);
- Designing health promotion campaigns especially for Indigenous people;
- Having culturally competent non-Indigenous staff;
- Making important health services available in rural and remote locations (so Indigenous people living in rural and remote areas do not have to travel to cities, away from the support of their friends and families); and
- Funding health services so they are affordable for Indigenous people who might otherwise not be able to afford them (Australian Indigenous HealthInfoNet 2014).

Achieving some of the suggestions offered by HealthInfoNet would help to reduce the unacceptable disparity in health outcomes between Indigenous and non-Indigenous Australians.

Conclusion

Indigenous Australians are currently not engaging with appropriate and effective mental health services in ways that will enable them to enjoy the quality of life that they might wish for. This has more to do with the absence of widespread appropriate and effective services than it does with any lack of motivation

on their part. Apart from the insecurely funded and over-stretched National Aboriginal Community Controlled Health Organisation (ACCHOs), there is a dearth of effective and sustainable services that take seriously the perspectives of Indigenous Australians and actively work to understand Indigenous experiences. To begin to address this situation, it will be necessary to hear what Indigenous people are saying with their words and their deeds—in Indigenous Australian terms, *Dadirri*, or *Ngara*, or *Yurringarnendi*: notions describing a sustained, situation-attuned, self-reflexive, and other-contemplative 'deep listening'—and to demonstrate that we have heard through a preparedness to work as equally contributing partners in the development of robust, ongoing, and effective solutions. If, indeed, addressing the social determinants of health is of particular pertinence to Indigenous Australian mental health and well-being—which would include not only those determinants of greater visibility, such as poverty and incarceration but, also, some less-apparent determinants, such as systemic racism, cultural continuity, and connection to country—then one approach might be to widen the mental health professional and service role. An adequate fulfilling of duty of care obligations, as well as promoting effective outcomes for Indigenous clients, would appear to mandate a 'public professional' role for both the professional and service—one of naked advocacy—in gaining non-health sector collaboration in addressing relevant determinants.

In some ways, the disparity between Indigenous and non-Indigenous Australians with respect to the incidence of mental health problems, along with mental health services, is symbolic of a global gap between high-income countries and low- and middle-income countries (LMICs). The global gap refers to the level of service provision that is required and the level that is available (White and Sashidharan 2014). At a global level, White and Sashidharan (2014) indicate a need for a greater consideration of the importance of culture and context with regard to the provision of services as well as a more balanced exchange of information between LMICs and high-income countries. Lessons learned, therefore, regarding the way in which mental health services can become more useful to Indigenous Australians will not only benefit the first nations of Australia but may provide important insights for other cultures as well.

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