CHAPTER TWO: CULTURALLY APPROPRIATE MENTAL HEALTH ASSESSMENT AND TREATMENT FOR INDIGENOUS PEOPLES

The current Aboriginal and Torres Strait Islander Queensland Mental Health Policy Statement advocates the promotion, improvement and maintenance of mental health amongst this diverse group of people. Hence, “diversity” is an apt word to use when speaking about the Aboriginal and Torres Strait Islander population, due to the different groups and communities that it comprises. It is not an easy task developing one set of rules that is expected to apply to all. This would be disrespectful, irrelevant and make light of a complex issue. Consequently, the following protocols should only be used as a guide and not be considered as an exhaustive account. It should further be noted that where “Indigenous peoples” is used in the text, it refers to the diversity within Aboriginal and Torres Strait Islander cultures.

Many Indigenous peoples define themselves as being part of a group, clan, or community, where there is common ownership of land, property and issues that arise. There are also shared beliefs and practices that promote harmonious living with each other and the land, and provide unique perceptions about life and a way of being in the world. This communal perspective sustained people traditionally and is still very much practised today. Hence, many Indigenous peoples view health within a holistic framework that encompasses the overall physical, social, emotional, spiritual and cultural wellbeing of their entire communities.

The 1994 United Nations (UN) declaration on “Discrimination against Indigenous Peoples” gives Indigenous peoples “the right to maintain, practise, develop, and teach their spiritual and religious traditions, customs and ceremonies”. Thus, provisions in the current Queensland Mental Health Act (2000) and National Standards for Mental Health Services also acknowledge that consumers must be allowed to maintain their cultural and religious values when making decisions about issues affecting their lives. This has immense implications for providers in the assessment, treatment, and management of mental illness. One of the problems of non-Indigenous attitudes to health care is its individualised approach that often does not involve and at times may inadvertently exclude families. However, taking an individualised approach to care requires tailoring treatment to suit the personal, cultural and religious beliefs of consumers. For many Indigenous peoples, this involves including family and community members into the therapeutic alliance. For all clinicians working outside their own cultural group, it is essential to open lines of communication with a range of people with cultural knowledge and understanding of the daily lives of consumers and their families. This involves working together with local practitioners, especially Indigenous Mental Health Workers or Primary Health Workers, to enable your understanding, language and practice to become more complimentary with, rather than alien or opposed to, the consumers’ own understandings. Conscious efforts to avoid making assumptions and challenging your own prejudices and professional practice will enable these cultural informants to guide you. It is important to utilise all avenues that provide support and strength to consumers and their families. It will also help mental health professionals make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable.
This chapter attempts to give staff an insight into some of the cultural beliefs and practices of Indigenous peoples and offers guidance in the following areas:

- Rapport Building;
- Families and Carers;
- Assessment;
- Treatment; and
- Compliance.

**Rapport building**

In many instances, Indigenous consumers with psychiatric problems do not access mainstream mental health services. Those services that have had some success have demonstrated flexibility and adaptability in work patterns and service development. Ultimately, it has required a genuine shift in the ways non-Indigenous mental health providers approach psychiatric assessments.

**Location of interview**

It is particularly important to interact with Indigenous peoples in an environment where they feel protected and comfortable. This may involve mental health providers travelling out into the community to see consumers, most likely in the home setting. This can be an invaluable strategy in the assessment process, because of the opportunity to access family members, who can be the richest source of information. Additionally, seeing the family in the home setting can aid in the process of determining the consumer’s customary level of self-care, in order to detect changes that might signify a mental disorder.

If Indigenous consumers present at the service, mental health providers should ensure that their work place is culturally friendly and appropriate. This may involve displaying Indigenous images and posters on the walls and distributing brochures that cater for Indigenous consumers. It may also involve team members endeavouring to see a consumer for an initial assessment at first presentation, instead of requesting the patient to return for a later appointment. All caring professionals working within the mental health care setting should be educated about Aboriginal and Torres Strait Islander cultures to enhance understanding.

**Consumer support**

Whenever possible, you should work in partnership with Indigenous mental health workers when engaging and working with Indigenous consumers. Thus, Indigenous mental health workers are invaluable in terms of culture and customary knowledge, accessing Indigenous supports and interacting with family networks. Their presence alone has the ability to place consumers at ease. They can also be utilised to act as cultural translators, due to their ability to communicate in a culturally appropriate manner. If an Indigenous mental health worker is not available, an Indigenous primary health worker should be involved. Another useful strategy could be advising consumers that they have the option of inviting a family member or nominating a support person to accompany them to the initial assessment.

**Language and interview techniques**

Mental health providers should begin by explaining their role and the purpose of the interview. Confidentiality and the rights of the consumer should also be discussed appropriately. This includes information about the complaints process. Be aware that an Indigenous person may not be willing or able to immediately and effectively engage in a discussion about the presenting illness. However, this does not mean that the consumer does not want to participate in the interview. Instead, factors such as
shyness, shame and wariness might be preventing immediate engagement. There might also be gender issues to consider.

Generally, when Indigenous peoples interact with each other for the first time, they often begin with making reference to where they are from (community and/or tribe) and whom their relatives are (immediate and extended family). In many ways, this serves to create a sense of identity and connection within oneself and between each other. Very rarely is the purpose of the visit immediately discussed upon meeting.

In consideration of these factors, it is generally a good idea to avoid asking questions about the presenting illness at the start of the interview, unless the consumer volunteers the information. Begin with non-threatening statements or topics to initially engage the consumer in conversation, placing him/her at ease. It is also more appropriate for mental health providers to be the same gender as the consumer whenever possible.

It is best to avoid using leading questions because Indigenous consumers should be encouraged to tell their own stories. This draws upon the strong Indigenous oral tradition and allows consumers to work at a pace that is comfortable for them. Mental health providers should also seek information from family and community members to assist in this process. This is an invaluable strategy, particularly in circumstances where consumers are unable to make decisions or have difficulty seeing things clearly. It will also help assess behaviours in a cultural context.

When questions are required, avoid using technical words or medical jargon and speak in an easy, open manner. Identify how to speak at a rate the person understands. The level of English understood will vary from individual to individual. If the consumer seems reluctant to answer, allow some additional time or even delay further questioning until later. Thus, some Indigenous peoples might take time to sit back and contemplate a question or point of view. Mental health providers should not be too hasty in determining this to be a sign of slow or impaired cognitive functioning. Rather, it could be simply a variation in communication styles. It is also worth keeping in mind that in some Indigenous communities, it is considered bad manners to be too inquisitive. Consequently, some consumers might resist answering too many questions because it contradicts their idea of privacy.

Some Indigenous peoples communicate using an indirect style of communication. This includes non-verbal as well as verbal interaction. For instance, direct questions might be considered rude in much the same way that too much eye contact could lead to feelings of being judged, especially if there are issues relating to shame. This should be used only as a guide, because this also differs from individual to individual.

**Sensitive areas**

Caution should be exercised when discussing bereavement, ceremonial business, sexuality, fertility, domestic habits and other sensitive areas. Bereavement or “sorry” business is a crucial part of culture. Funerals often involve entire communities and in some areas the name of the deceased is not uttered. It is not uncommon in some communities for Indigenous peoples to express their grief through self-injury, in the form of “sorry cuts” or other physical manifestations of grieving. Consequently, mental health providers should be aware of this when making their assessment. Community consultation should take place when determining what is acceptable to aid this process.
Examples of “men’s business” and “women’s business” could include discussions involving ceremonial business, sexuality, fertility, health and domestic habits. Generally, it is not appropriate to discuss “men’s business” in the presence of females and children. This is reciprocated when discussing “women’s business”. When engaging the consumer in a discussion about an area of sensitivity, it is best to speak in an honest and open manner. Acknowledge that it is a sensitive area, and explain the purpose of asking about that particular issue. Ask if the consumer is comfortable with proceeding, and if unsure, how to proceed.

Summary
When engaging with Indigenous consumers, the following points should be considered:

- Determine the best location for the interview, ensuring that it is an environment where the consumer will feel protected and comfortable;
- Arrange for an Indigenous mental health worker to be present, or a support person;
- Be aware of gender issues;
- Allocate more interview time;
- Begin with non-threatening statements or topics;
- Explain your role and the purpose of the interview;
- Speak in an easy, open manner and speak at a rate the person understands;
- If the consumer seems reluctant to answer, allow additional time or delay further questioning until later;
- Be aware of asking direct questions or too many questions;
- Avoid using leading questions and encourage the consumer to tell their own story;
- Do not make assumptions and clarify throughout the process;
- Use appropriate eye contact; and
- Use caution when discussing areas of sensitivity.

Families and carers
In many instances, it is primarily families and carers who sustain the operational effectiveness of mental health services. This is evident when considering the limited resources and funding given towards service provision. A large proportion of the Indigenous population lives in remote communities and does not have immediate access to specialist mental health services. Consequently, families and carers experience undue responsibilities and pressures due to significant gaps or inadequate practice in mental health service delivery.

The home environment
Without the contribution of families and carers, many consumers with complex needs could not be supported to live in a family or household environment. This would result in more expensive alternative care and possibly greater anxiety for consumers and their families. For Indigenous consumers, this would have devastating consequences, due to the importance of maintaining cultural links with one’s land, family and community. Consequently, it is in the best interests of all parties to provide emotional and social support to families and carers. Mental health providers must allow consumers to maintain continued participation in community life and keep existing supportive relationships.
Consultation
Mental health providers should be aware that families and communities play a huge part in the lives of Indigenous consumers. It is very common for them to have a number of carers, due to the extended family networks that many of them have. Those who are actively involved in the care of consumers should be consulted in all aspects of assessment, treatment and management. There may be many family and community members who need to be consulted and it may take time. However, this consultative process is necessary for developing a good working relationship with the consumer’s family and community. It will also enable mental health providers to make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable. Staff will also have a greater range of key informants to access for information and assistance.

Information, education and training
It is imperative for families and carers to receive information about mental health services, mental disorders, mental health problems, available treatments and support services. This should include information about early warning signs, medications and side effects and the rights and responsibilities of all parties. It also includes information about local services and agencies that can be utilised for support, respite and back-up assistance, if needed.

Summary
When working with Indigenous consumers, the following issues need to be considered:

- It is important to provide emotional and social support to families and carers;
- It is more appropriate for the mental health provider to be of the same gender as the family member or carer;
- They should be consulted and encouraged to participate in all aspects of their care;
- It is common for Indigenous consumers to have an extended group of carers, and there might be many family and community members who need to be consulted;
- Families and carers are key resources to access for information and assistance;
- They should receive information, education and training about the consumer’s illness, early warnings signs, treatment options, medications, and rights and responsibilities; and
- Families and carers should be advised of local services and agencies for support, respite and assistance.

The assessment of mental health
Cultures are made up of values, personal experience, behaviour, concepts of shame and psychological and social reward. Current classifications tend to obscure the complex relationships between culture and mental disorder, because scientific rationality is sometimes in conflict with cultural aspects. There is no doubt that mental disorders exist within the Aboriginal and Torres Strait Islander cultures. However, cultural explanations for causation must also be fairly and thoroughly assessed before diagnosis can be successful.

Spirituality
Spiritual dimensions are a part of all cultures. Within Indigenous Australia, a diversity of tribes and clans traditionally had their own language, values and beliefs. Tribes and family groupings commonly had a sacred symbol or totem, and spiritual significance was attributed to certain sites. These values and beliefs were based on cultural lores,
which were conceived in the “Dreamtime” and covered such topics as morality and interaction with all living things. Thus, the “Dreaming” was widely accepted as being the origin of the creation of the land, animals and peoples.

Historical factors had a destructive impact on Aboriginal culture. Nonetheless, Indigenous peoples were able to maintain their spiritual connection with the “Dreaming”, and possibly survived because of it. Due to the diversity of peoples within Indigenous Australia, there are many different spiritual beliefs. For example, some might believe that when a person dies, death only occurs in a physical sense and the spirit returns to the “Dreaming” in the same form. Visions of deceased spirits might sometimes be talked about and there are many who believe they can communicate with their ancestors. Sometimes dreams are also considered to be visitations either by spirits or ancestors. However, others might believe that loved ones return to the dreaming in a different form, usually as an animal or other living thing of spiritual significance. What their identity has become is determined by signs or through some other method.

Other known beliefs include the following:
- Thoughts and feelings can be shared telepathically between closely related people;
- Magic spells can be cast in a multitude of ways;
- These include “pointing the bone,” being “sung” and being “caught” using certain parts of flora or personal items from the victim (e.g. a strand of hair);
- These spells can be used to cause ill health and death;
- These spells are sometimes cast as punishment for contravening traditional Aboriginal laws by tribal figures (for example, the “Kadaicha” man);
- Dangerous and unseen spirits can make people sick by various methods, including trying to consume people’s spirits;
- Someone who is acknowledged to be a traditional healer (for example, the “Ngangkari”) can be sought for help in all manner of spiritual, physical and psychological issues; and
- They have the ability to cure illness or strange behaviour and protect people from danger.

There are many other beliefs and values about spirituality that are held either by individuals, families, or communities. Consequently, mental health providers should avoid stereotyping and keep an open mind. When scientific rationality is in conflict with culture, caution should be used in making assessments. Spiritual experiences and beliefs should not automatically be labelled as hallucinations, delusions, pathological thinking, or a sign of emotional imbalance. Understanding the social and cultural relevance of these experiences requires respectful consultation with family, Indigenous health workers and other cultural informants from the community.

**Psychological processes**

Psychological processes refer to observations made by mental health providers about how a consumer is behaving, what they are thinking about, and how they are feeling. It is usually the first part assessed during a Mental Status Examination and is generally composed of five areas:

1. Appearance;
2. Behaviour;
3. Thought form;
4. Thought content; and
5. Emotion (otherwise known as ‘affect’).
1. Appearance
This is a brief description of how the consumer looks and presents. If the consumer’s self-care appears to be very poor, it is important to ascertain how long this has been the case. Other areas of interest include recent changes in the consumer’s appearance. Information can be sought from the consumer, family members and carers and by approaching local service providers (for instance, a health worker). It is also important to consider the distance or mode of travel the consumer experienced to reach the appointment. Another vital step is to find out what are acceptable standards of appearance in that community, before making a decision.

2. Behaviour
Behaviour can give many clues to how a person is feeling and what they are thinking. A consumer might be restless and have difficulty staying still. This could indicate a multitude of things, including withdrawal from alcohol or nervousness about being interviewed. Conversely, the consumer might be slumped in a chair and be difficult to engage in conversation. This could indicate depression, sadness, shyness or shame. The consumer could also be acting in a very strange way, displaying odd movements of the body or face. There might be behaviour that suggests they are listening to something or someone, or that they are angry or worried. Mental health providers need to be open-minded and observant about this area, be careful to separate signs of illness from culturally appropriate behaviours and avoid making assumptions.

3. Thought form
Thought form refers to how thoughts are connected. It looks at the way thoughts are ordered and put together and whether this is done in a logical and clear way. This is determined by the consumer’s speech.

The consumer might speak in a slow and hesitant manner, with many gaps and unfinished sentences. It might be fast and seem pressured, as if ideas are flying through their mind. The consumer’s speech might also be normal in pace, but odd as if there is a private code. Certain words might be used because they rhyme, or secret meanings might be attributed to words that are different to what the words actually mean. In some instances, the code might be impossible to guess. The consumer might begin discussing a subject and then talk about something else that is unrelated. In some instances, the new topic might be related to the initial discussion, but that connection is “loose” and illogical. The consumer might also seem to make up words, or use words that have no meaning or link to each other.

In assessing this area, it is advisable to firstly determine how well the consumer knows English. For many Indigenous consumers, English might not have been their first language. There might also have been factors that prevented the consumer from getting an adequate education. Consequently, the consumer might exhibit problems with pronunciation, comprehension and grammatical structure. Strategies that can be used to ensure a fair assessment is made include ensuring that an Indigenous mental health worker, Aboriginal health worker, or a support person is present to act as an interpreter or translator. It is also best to avoid using medical jargon or technical words. Delayed answers or minimal speech should not automatically be considered as a sign of slow or impaired functioning.

4. Thought content
Thought content refers to what the consumer is thinking about. Abnormalities in mental functioning can occur if there are problems relating to experiences in sensory modalities, which include hearing, sight, taste, smell and touch. These experiences are known as “hallucinations”. For instance, a consumer might speak of hearing voices, or seeing someone or something. Experiences with the other senses (taste,
smell and touch) are uncommon, but there have been instances where epilepsy sufferers and substance abuse users have reported sensations.

Abnormalities can also occur if there are problems relating to ideas. The consumer might become preoccupied about something to the point that it becomes too excessive. These ideas can be understandable given the circumstances, or clearly abnormal and obviously false. These experiences are known as “obsessions”. If the focus of the preoccupation places the consumer or another person at immediate risk, the mental health provider must take the matter seriously. An example would be a consumer constantly thinking about death.

In certain instances, some ideas can be so bizarre that it seems unlikely that they are true. However, the consumers are convinced about they are reasonable, even when faced with convincing evidence to the contrary. These ideas are known as “delusions”. The most common are delusions of persecution, whereby consumers are convinced someone or something is intent on seriously harming them (paranoid delusions). Other delusions include believing they are very important or famous people or have extraordinary powers (grandiose delusions).

As already noted, caution must be exercised where cultural experiences and ideas are concerned. This is because not all reported cases signify that there is a mental health problem. Staff should explore whether such experiences and ideas make sense in cultural terms and are consistent with values and beliefs expressed by the family or community the consumer identifies with.

5. Emotion

The purpose of this section is to get an understanding of the consumer’s mood. Areas assessed include the type of mood exhibited, its appropriateness in the interview setting and in consideration of what concerns are being expressed, and the mood’s consistency. This is generally determined by what consumers say about their feelings and how they present.

In some instances, how consumers look and sound may not correspond. Consumers might look very happy but talk about being down and depressed. On the other hand, consumers might look and sound sad at the same time, but be completely different later. Their mood seems to be continually changing from moment to moment (labile). Other examples include when consumers look and sound unusually happy (euphoria) or when they are very sad (depressed). Consumers might also not display any mood at all and appear flat (blunted).

From a cultural perspective, a common belief amongst many Indigenous peoples across the world, including Australia, is that revealing or showing emotion is a sign of weakness. Consequently, they might present as being reserved, even when discussing traumatic or happy experiences. This should be considered when determining flat affect. Caution should also be used in not confusing shyness or shame with sadness.

Cognitive processes

Cognitive processes are the second part assessed during the mental state examination. This area determines whether there are any signs or clues suggesting that there is something affecting the consumer’s level of consciousness. It also seeks to explore the mental functions that are necessary for thinking things through and obtain a rough estimate of intelligence.
This part is generally composed of six areas:

1. Attention and concentration;
2. Orientation;
3. Memory;
4. Intelligence;
5. Insight; and

1. Attention and concentration
This area seeks to determine whether consumers are alert and conscious of what is happening in the interview. In some instances, consumers might be easily distracted or unable to keep their mind on one thing at a time, which could possibly require further exploration. In the event that it is not obvious whether there are problems, a simple test might be administered. In doing so, it is worth keeping in mind that many Indigenous consumers might have a vastly different concept of what is considered to be general knowledge in comparison with the general population. Therefore, it is best to ensure that whatever topic is used to test this aspect is one that the consumer is familiar and comfortable with.

2. Orientation
Orientation is important to assess because it determines whether consumers understand their position in person, place, and time. Orientation in person refers to their awareness of who they are and who those around them are. Orientation in place refers to whether they recognise where they are. For example, they might think they are at home, when in fact they are at the hospital. They might also think they are in another community. Lastly, orientation in time refers to whether they know when it is. Most people might not know the exact date. Therefore, it might be more appropriate to ask the year, month, or day of the week. Obvious disturbances of orientation could indicate a serious problem.

3. Memory
Generally, three areas are assessed:
   a. Immediate recall—whether the patient is able to remember things straight away;
   b. Short-term memory—whether the patient is able to remember things after a few minutes;
   c. Long-term memory—whether the patient can remember things from a long time past.

It is best to ensure that the topics used to test these areas are familiar to consumers. For instance, in testing long-term memory, it would be more appropriate to ask consumers to recall the names of family members instead of the last five Prime Ministers of Australia.

4. Intelligence
Evaluating intelligence is a very complicated and controversial subject. This is because of the cultural and educational differences between Indigenous Australians and mainstream society. In the Mental Status Examination, intelligence is assessed very generally. Factors considered include communication skills, ability to perform basic calculations and general knowledge questions. However, what if the consumer has a limited understanding of English and has only completed a minimal amount of schooling? These are some of the issues that need to be addressed before a fair assessment can be made.
Some strategies that can be used to aid mental health providers include:

- Establishing the level of education of consumers;
- Establishing how efficient consumers are with English and its usage and whether it is their first language;
- Ensuring that general knowledge questions are appropriate, considering that many Indigenous people have a different concept of general knowledge;
- Ensuring that how consumers present and how they communicate is not mistaken for slow or impaired functioning. For example, a consumer might be shy, or generally sit back and contemplate a question before answering;
- Actively involving Indigenous staff and support people for background information and assistance in the assessment process; and
- Being aware that the skills mainstream society value are not necessarily the same as what many Indigenous peoples view as important to survival, irrespective of how much schooling they have completed.

5. Insight

Insight refers to whether consumers are able to articulate whether they have a problem. Most people with mental health problems have some idea that something is wrong, even if they are unable to identify what it is. However, others might not be aware that something is amiss, despite it being obvious to everyone around them (for instance, many people suffering from schizophrenia). Some people who are aware they have a problem might be unwilling to admit it (for instance, someone suffering from alcoholism), while others might give the impression that they do not seem to care (for instance, some people with a serious personality disorder). An assessment of insight is very important because it can give mental health providers clues as to diagnosis. It can also determine what treatment is appropriate under the circumstances.

6. Judgement

The final section of the mental health examination involves determining whether the condition consumers are suffering from is affecting their ability to assess what is happening around them and to them, and to make important decisions. Thus, when judgment is impaired, consumers might not be able to make decisions in their best interest, or may make decisions that might cause harm to others. Judgment can be impaired temporarily or for a greater duration of time. For instance, a seriously depressed person might believe that there is absolutely no point in continuing to live and be planning to suicide. Another consumer might be hearing voices telling them to harm someone. Someone who is intoxicated might become extremely aggressive but be completely docile when sober. All of these people are at risk of making decisions that might result in harm to themselves or others and need to be protected. Mental health providers should consult with Indigenous staff, families and community members to ensure that an accurate assessment is made.

Summary

When assessing Indigenous consumers, the following issues need to be considered:

- Spiritual beliefs should not automatically be dismissed as hallucinations, delusions, pathological thinking or a sign of emotional imbalance;
- Find out what is considered to be an acceptable standard of appearance in the consumer’s community;
- Mental health providers need to be open-minded and observant when assessing behaviour and emotion and avoid making assumptions;
- Do not confuse shyness or shame with sadness, or a reserved response as evidence of flat affect;
- Establish how confident consumers are with English and if it is a first language;
- Delayed answers or minimal speech should not automatically be considered as a sign of slow or impaired functioning;
- Determine the level of education of consumers;
- Ensure that general knowledge questions are appropriate, considering that many Indigenous consumers might have a vastly different concept of what is considered general knowledge by the general population;
- Actively involve Indigenous staff, families and community members for background information and assistance in the assessment process; and
- Be aware that the skills mainstream society values are not necessarily the same as what Indigenous peoples consider important to survival, irrespectively of how much schooling they have completed.

**Therapies for Mental Health**

Mental health providers have an obligation to provide the best possible care to consumers. In formulating Care Plans to achieve this, staff need to consider how Indigenous peoples view mental health. In practice, this requires open-mindedness and being receptive to the idea that there are many pathways that lead to recovery.

**The therapeutic relationship**

The development of a positive therapeutic relationship at the onset of treatment is critical. This is because it can influence the final outcome. Generally, an individualised approach to care is taken with each consumer. This approach has met with universal approval from policy makers, educators, mental health providers and consumers. However, there appears to be a lack of shared understanding of its meaning. Further exploration of this term is needed for greater clarity.

Taking an individualised approach to care involves a commitment to treat each consumer as unique and tailoring care around his/her needs. It includes not making assumptions because of someone’s age, gender or ethnicity. It must be remembered that people with a mental illness have the same basic human rights as all persons. They have a right to dignity and respect as human beings. They also have a right to autonomy, choice and control over aspects of their lives, including their encounter with mental health services. By failing to recognise this, staff risk alienating consumers and treatment being unsuccessful.

Consumers are often the least powerful people in the health care system. This is due to their vulnerability in being unwell, and most often their lack of professional knowledge in the area of mental health. Consequently, an uneven distribution of power exists between mental health providers and consumers, which can act as a barrier in forming genuine partnerships. To counter this threat, there must be a sense of collaboration and equality in decision-making. These characteristics are extremely important because they promote independence by encouraging consumers to take responsibility for their own health. By establishing agreement at the beginning of treatment, there will be a greater understanding of what the needs of consumers are and how these can be met. Ultimately, this will increase the effectiveness, relevance and acceptance of treatment and the chances of success.

Close attention needs to be paid to how consumers cope with being diagnosed with a mental illness and the subsequent call for treatment. This is due to the stigmatisation and fear that exists within society about mental illness. On the one hand, a diagnosis may give some people understanding about the symptoms they have exhibited and establishes eligibility for assistance and intervention. However, it can also create social disadvantages for people who are labelled, due to the erroneous assumptions and stigmatisation of those who are considered different. This can sometimes act as a
barrier in forming a genuine partnership and adversely affect the outcome of treatment. Consequently, a great deal of sensitivity is needed.

Other important characteristics of forming a quality relationship include establishing a climate of trust and safety through openness. This can be attained through active listening and the communication of acceptance and respect. Staff should also verify with consumers their expectations about treatment and their readiness for change. This ensures that consumers have a realistic outlook and are not being set up to fail.

A positive relationship between consumers and staff can represent a therapeutic intervention in itself. It can be life sustaining for many consumers, in acting as a safety net and reducing hospitalisation. The evidence from the literature suggests that a psychotherapeutic relationship is very important to the ability of clients with severe and persistent illness to live in the community. This adds further weight to establishing a positive relationship at the onset of treatment.

**Traditional healing**

In respecting individuality, the needs of consumers from different ethnic backgrounds, including Indigenous Australians, must be accommodated. Mental health providers must ensure that consumers and their families maintain their cultural beliefs and practices. In order to achieve this, it is important to firstly identify what those beliefs and values actually are. Cultural beliefs and values still remain important for many contemporary Indigenous peoples. This is possibly because they provide meaning to life, and are a source of guidance, strength, and comfort, particularly in times of illness. Consequently, staff should work with consumers and their families to ensure that traditional modes of healing can be accessed for those who desire it, while continuing to provide appropriate psychiatric care.

In taking an individualised approach to care, staff need to be aware of the Indigenous concept of time. Unlike mainstream society, time is not seen as being the dictator of life. This has repercussions for what is considered important and when things are done. For instance, family and community for an Indigenous person are a high priority. If a family or community need arose, it would take precedence over a previously scheduled appointment, irrespective of how adversely it may affect the individual involved. Similarly, many Indigenous peoples live in the here and now, which is a combination of the past and present. Hence, the future is considered to be an alien concept. This would have implications if therapeutic interventions were focused on improving future health status, without immediate consequence. A useful strategy in this situation would be to provide brief, intensive, specific problem-orientated interventions that are effective and relevant.

Prior to colonisation, the Indigenous peoples of Australia had their own healers for the examination and restoration of health. This is still the situation today. These traditional healers are known by many names, due to the diversity of Indigenous dialects and languages. In Central Australia, they are often known as “Ngangkari”.

The Ngangkari are Indigenous healers who specialise in treating people with mental health problems. They can capture negative energy inside the body and expel it, mostly by using the mouth, hands and breath. This negative energy is generally caused by illness and disease, or afflictions from dangerous spirits. The Ngangkari see negative energy as forming something solid and physical, such as pieces of wood, sticks or stones. It can also come in the form of dirty blood. Consequently, treatment involves removal of objects from where they have been lodged in the bone or flesh, or using suction from the mouth to draw out mouthfuls of dirty blood, without damaging the body internally or externally. Sufferers are also able to see the sickness being
taken from their bodies and observe what caused their suffering. After removal, the Ngangkari generally dispose of objects by throwing them into the wind, or burying them somewhere. When removing dirty blood, it is always spat out and never swallowed. Ngangkari healing treatments clean wounds completely, which supports the healing of the flesh.

The Ngangkari can touch the spirit of people who are sad and depressed, or feeling not quite themselves. They might be feeling a displacement of their spirit, or believe that their spirit is missing. These traditional healers can locate a lost spirit or reposition a dislocated spirit, making a person feel whole again. The Ngangkari can also manipulate misaligned and dislocated bones to put them back into place, taking the pain away at the same time. They have an in-depth knowledge of the whole anatomy of the body and can detect changes quietly easily. They can also render assistance to people who are dying, to protect them from preying spirits. This is achieved by cleaning the body and spirit, to ensure that the afterlife is safe and unaffected.

The Ngangkari can also chase away unseen spirits. These are negative spirit powers that are troublesome and dangerous and who have the potential to physically harm people or make them very sick. These healers identify the negative spirits and pursue them until they no longer pose a threat to others. Additionally, they have the ability to heal people who have been inflicted.

A special power given to the Ngangkari is the ability to travel around in their spirit bodies. While asleep, their spirit bodies take flight and they can visit the sleeping spirits of others. When sick or injured spirits are identified, the Ngangkari are able to provide treatment straight away. Those who need assistance ask for help in their dreams, when their spirits call out. Many Ngangkari choose to treat people first from their spirit body, because they can make a better diagnosis and provide a more effective treatment. Ultimately, this gives them the power to look over the person externally and internally, where the spirit dwells.

The Ngangkari can be men, women or children. Children make the best Ngangkari because as they grow up, their powers increase. Knowledge and power is given to them to enter the spirits of others and to give the healing breath and touch. Instruction is by other Ngangkari who teach by example. They are taught from a long heritage of traditional healing. Powerful spirit figures, known as “Karparinypa”, also bring them special sacred tools known as “mapanpa”. These tools come in many forms, including slivers of bone and sharp stone blades. The Ngangkari use their own “mapanpa” to heal others, and generally store their tools inside parts of their own body, such as the palm of the hand. These tools help them to enter into people’s spirits and heal from within.

The Ngangkari have not had much success in treating substance misuse, particularly in cases where the body has started to deteriorate. However, they can help in other areas. It should further be noted that the Ngangkari are not comfortable with the shedding of blood during operations. This is because spilled blood is seen as wasted blood. They also do not agree with blood transfusions, because putting other people’s blood inside a sick person is viewed as very dangerous. Thus, these traditional healers clean blood using the old methods, without cutting or opening the skin. They consider new techniques used by medical practitioners to be unclean and unsafe.

The Ngangkari work on a level that other healing providers cannot. They heal in a way that can neither be seen, nor written down. They enter the body by way of the spirit and heal from within, using the healing breath and touch. The law for all Ngangkari has its origins in the Dreamtime and they have practiced their healing powers ever since.
For centuries, Indigenous peoples have consulted traditional healers, including the Ngangkari, for their ancient healing treatments. They are considered to be doctors, in much the same way that mainstream society views medical practitioners.

There are many obvious differences between the clinical approach and the Indigenous approach in treating mental illness. However, both share the same goal in working towards healing the sick and improving quality of life. The Ngangkari already work alongside clinical staff in some health centres and this has proven to be very successful. If Indigenous consumers seek the help of traditional healers, mental health providers should respect their values and cultural beliefs. It is also advised that staff use these beliefs in the care of those who hold them. In combining mainstream and Indigenous therapies, consumers will ultimately receive treatment that acknowledges diversity and is individualised in its approach.

It should also be noted that Indigenous peoples sometimes use bush medicines to treat illnesses and ailments. Mental health providers should check with consumers, particular if there are concerns about adverse effects when used in combination with psychiatric medications.

**Pastoral healing**

Christianity was introduced to Indigenous Australians in early colonial times, followed by other religious persuasions. Subsequently, many have incorporated religious beliefs and practices into their lives in varying degrees. Mental health providers are already required to ensure that consumers maintain their religious values when decisions are made about issues affecting their lives. Using these same principles in caring for those who hold them may increase the effectiveness of treatment.

It is important to fully utilise all avenues that provide support and strength to consumers. Religious beliefs are a great source of inspiration for many people, offering encouragement and hope for the future. Religious practices, such as prayer and meditation, can enhance self-awareness and provide peace from stress and anxiety. Hence, religion for some people offers guidance and a way of coping with the vicissitudes of life. It is quite common for consumers who have religious values to seek help from a clergy member. Most often this is in the form of pastoral counselling. Other methods employed by consumers could include joining a religion-based support group that offers support and assistance for them and their families.

Mental health providers need to be aware of what the personal and religious beliefs of consumers are in order to take an individualised approach to their care. If clergy members are actively involved with consumers, providers should work in collaboration with them. It may involve providing education and skills to clergy about psychopathology in a consultative framework. In consideration of the increasing diversity of people’s worldviews, providers must also reflect on their own belief systems and ensure they do not prejudice others who hold different views.

**Alternative therapies**

There are other forms of alternative therapy that Indigenous Australians might be familiar with, particularly those living in metropolitan areas. Examples of these include naturopathy, homeopathy, acupuncture, aromatherapy and Chinese herbs. Alternative therapies are generally viewed with controversy, due to the lack of regulations within these industries. Mental health providers need to be aware if clients are accessing alternative therapies in combination with psychiatric care. This is to ensure that consumers do not suffer adverse effects, particularly if they are taking psychiatric medications.
Summary
When treating Indigenous consumers, mental health providers need to be aware of the following:

- There is more than one pathway that leads to recovery;
- Developing a positive therapeutic relationship is critical;
- An individualised approach to care involves tailoring treatment to suit the personal, cultural and religious beliefs of consumers;
- There must be collaboration and equality in decision-making in order to form genuine partnerships and increase the effectiveness, relevance and acceptance of treatment;
- Everyone needs to be aware of the stigmatisation of mental illness and the impact it has on consumers;
- A positive relationship between consumers and providers can provide therapeutic intervention in itself;
- Consumers and their families must be able to maintain their cultural beliefs and practices;
- Traditional Indigenous healers specialise in treating people with mental health problems;
- They use ancient healing treatments without damaging the body internally or externally;
- If Indigenous consumers seek the help of traditional healers, mental health providers should respect their decision, while continuing to provide appropriate psychiatric care;
- Indigenous people sometimes use bush medicines to treat illnesses;
- Consumers must maintain their cultural and religious values when making decisions about issues affecting their lives; and
- Mental health providers need to be aware if clients are accessing other forms of therapy in combination with psychiatric care, particularly if they are taking psychiatric medications.

Compliance
Compliance in health care is a complex issue and has been defined as being the extent to which the consumer’s behaviour coincides with medical or health care advice. Mental health providers are seen as being the definers of “proper” treatment and this has been legitimised and reinforced through various legislative measures, including the current Mental Health Act (2000). If the patient does not follow medical advice, the Act allows the health professional to exert influence and legitimately override the wishes of the patient, based on a belief that the individual is deemed to lack competence. Indeed, it has been argued that one of the primary reasons for a high rate of non-compliance with treatment in mental health is that the impact and nature of illnesses interferes with the ability of individuals to make sound, “rational” judgments. However, mental health providers must exercise caution in this area. This is because there are a multitude of factors that can influence compliance with treatment, other than the impact and nature of illnesses.

Consumer-related influences: Non-compliance is seen by many mental health providers as an issue about cost and the effective use of resources and has become a major factor in developing new forms of medications and treatments. The introduction of depot injections is an example. However, non-compliance is also about individuals, their attitudes and perceptions and the consequences of non-compliance to themselves. There are many factors that determine a consumer’s compliance behaviours. These include gender, social class, ethnicity, cultural background,
educational level and socio-economic status. These factors shape an individual's values and beliefs, which guide actions and decisions regarding medical advice. When unrecognised differences in needs, values and expectations exist between consumers and mental health providers, these differences might have detrimental effects on the therapeutic process. One important predictor of compliance is whether consumers feel that the prescribed treatment is having a positive effect on everyday life. For example, negative feelings about taking medication and harmful side effects can adversely affect adherence to treatment regimes. Another important predictor is the relationship that consumers have with mental health services. Institutional racism can act as a barrier to health care for ethnic minorities, including Indigenous Australians.

Individual prejudice and a general lack of respect can also be barriers. This can have detrimental effects on the therapeutic alliance and compliance, further alienating Indigenous consumers and their families from mainstream services. It is necessary to be aware of these issues and ensure that services are welcoming to Indigenous consumers. Mental health providers need to be aware of their own values and beliefs systems and avoid making personal judgments. Indigenous consumers need to feel comfortable accessing services and staff to discuss treatment if problems arise. It has been argued that quality of care is dependent upon the abilities of consumers to verbalise their opinions and be articulate when questioning treatment. This can be prejudicial for Indigenous consumers, particularly if English is not their first language. There are also cultural factors to consider, in the sense that Indigenous consumers might have a fear of asking questions. Consequently, Indigenous mental health workers should be utilised whenever possible to provide support to consumers and to act as cultural interpreters. Significant others should also be included into the therapeutic alliance.

As noted earlier, the Indigenous concept of time can have repercussions for what is considered important and when things are done. If a family or community need arose, it would generally take precedence over a previously scheduled appointment, irrespective of how adversely it might affect the individual involved. This is because family and community for an Indigenous person are a high priority. Mental health providers need to be aware of this and avoid making assumptions.

**Environment-related influences:** Recent statistics indicate that the Indigenous population is still much sicker, younger and poorer than the non-Indigenous population. In many Indigenous communities, there are issues relating to overcrowding, unemployment and a lack of on-site services and resources to cope with the growing needs of the community. These factors can adversely affect compliance. For example, overcrowding could impact on the ability of consumers to safely store medication in the home environment. Unemployment could prevent them from meeting ongoing prescription costs and having adequate transportation to attend appointments. Mental health providers need to explore and understand environmental constraints on consumers and develop realistic solutions and strategies in the best interests of all parties. In rural and remote areas, there are also the added burdens of isolation and a lack of access to specialist mental health services. This places more responsibility on local primary health care clinic providers, who might not have a background in mental illness. In periods of unwellness, Indigenous consumers often have no choice but to leave their communities in order to receive appropriate psychiatric treatment. This can be a frightening and daunting prospect because of the importance Indigenous peoples place on maintaining cultural links with one’s land, family and community. Consequently, this can have a detrimental impact on compliance and affect the therapeutic process. In such situations, mental health providers need to consult with those who are actively involved in the care of consumers to determine the best course of action to take. It may involve family members accompanying consumers when
leaving the community to assist with compliance. If such a course of action is taken, it is imperative that arrangements are made for family members as well that addresses accommodation and other vital supports.

**Professional-related influences:** Compliance is a complex ideology based on professional beliefs concerning the “proper” roles of consumers and mental health professionals. The dominant view is that the role of the professional is to diagnose, prescribe and treat, while the reciprocal role of the consumer is to comply with such diagnosis and treatment. Thus, consumers are considered passive recipients in their own health care. When consumers do comply with treatment, professionals sometimes assume that insight has been achieved and that a collaborative and trusting relationship has been developed. However, other factors may motivate compliance, including the perceived threat of withdrawal of treatment and rejection by the professional. The knowledge that non-compliance can lead to compulsory treatment by invoking the current Mental Health Act (2000) may also be a primary motivating factor. When consumers fail to follow rules, they are sometimes labelled as non-compliant, defaulters and as incompetent. This can be unfair however, due to the negative impact of labels and an inherent tendency to blame the consumer when they differ from professional opinion and prescription. Thus, consumers are individuals who construct and give meaning to their encounters with professionals, and actively evaluate treatments prescribed and advice given. They have a right to treatment that suits their personal, cultural and religious beliefs. Consequently, consumers need to be viewed as active participants instead of passive recipients in their own health care. This may involve mental health professionals letting go of some of their traditional roles and exploring how they can understand and participate in the decisions that consumers make about their treatment. The role of mental health professionals working with Indigenous consumers should be to challenge at an individual level their own prejudices and professional practice. A collaborative and trusting relationship is one that emphasises consumer rights, the need for culturally appropriate information and the importance of two-way communication and decision-making.

Many of the problems with non-compliance are associated with poor communication. Poor communication may be due to social and educational barriers and cultural differences in understanding the role of medicines. This can form inequalities in the relationship leading to an imbalance of power between professionals and consumers. When working with Indigenous consumers, it is advisable to communicate treatment regimes and advice with clarity, brevity and emphasis and to actively listen to what the consumer has to say. It is also important to offer enough time to the consumer and to leave space to talk about problems concerning medications or side effects. This is because a strong predictor of medication compliance has been found to be the consumer’s perception of the provider’s interest in him/her as a person. Indigenous mental health workers should be utilised, whenever possible, to assist in this process. Significant others of the consumer should also be included in discussions about treatment regimes. Mental health providers should ensure that they have received adequate training and/or resources on mental health and safe medication management to provide advice on these matters. An example of an interaction between a mental health worker and an Indigenous consumer in a remote North Queensland community as described by the worker illustrates some of these points:

“... one of them said to me; ‘I’m not gonna have that medication, I’m not gonna have your tablet, you think I’m mad, you think I’m going off’, and swore me deep, deep down. And I said; ‘That’s alright.’ And now he turned round said; ‘You know what, I needed medication because my little brains were tired, it was doing overtime ... I just got into drugs, just so that I can ..., I thought I’d shut it down.’”
Other factors that can hinder compliance behaviours include a high turnover of staff in mental health services. This is because of the unsettling affect this has on the recovery process. It takes time to build a therapeutic relationship with consumers, based on trust and continuity of care. This has particular relevant for Indigenous consumers, considering that many with psychiatric problems find it already difficult to access and engage with mainstream mental health services.

**Treatment-related influences**

Indigenous consumers are often coping with multiple issues in their lives and could already been taking medication for other health conditions. Mental health providers need to be aware of these medications and ensure that new medications are complementary. Treatment regimes should be as simplified as possible and compatible with existing routines that consumers already have. This is because complex dosage schedules can act as a barrier to compliance. Brand substitution can also cause confusion. Strategies to address this include dispensing medication in Webster Packs or Dosette Boxes. In the event that mental health providers suspect that consumers have other undiagnosed conditions that require intervention, referrals need to be made to such services. An example could be if the consumer has drug and alcohol issues.

As noted earlier, mental health providers need to be aware if consumers are experiencing any unwanted side effects from medication and make adjustments if needed. It is extremely important to provide sufficient information and support during this difficult phase of treatment, and evaluate the satisfaction of the drug with the consumer, including objective and subjective symptoms.

Another factor affecting compliance is that treatment may not be as effective as a consumer expects because of unrealistic expectations concerning the medication’s benefit/risk ratio. Conversely, if treatment is working well, consumers may stop taking medication because they experience no further symptoms and think that it is no longer required. Mental health service providers need to be aware of these factors, have an open relationship with consumers and encourage discussion about treatment. Lastly, family members and carers also need to be included into the therapeutic alliance. This will help mental health professionals make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable.

**Summary**

When treating Indigenous consumers, clinicians should consider the following:

- There are a multitude of factors that can influence compliance with treatment, other than the impact and nature of illnesses;
- One important predictor of compliance is whether consumers feel that the prescribed treatment is having a positive effect on everyday life;
- Another predictor is the relationship that consumers have with mental health services;
- Indigenous consumers may have difficulty verbalising their opinion and articulating themselves when questioning treatment, due to language barriers and cultural differences;
- The Indigenous concept of time can have repercussions for what is considered important and when things are done;
- Environment-related influences can adversely affect compliance, including issues relating to overcrowding, unemployment, and a lack of on-site services and resources to cope with the growing needs of the community;
- In rural and remote areas, there are also the added burdens of isolation and a lack of access to specialist mental health services;
• The role of mental health professionals working with Indigenous consumers should be to challenge at an individual level their own prejudices and professional practice;
• When working with Indigenous consumers, it is advisable to communicate treatment regimes and advice with clarity, brevity, and emphasis, and to actively listen to what the consumer has to say;
• It is also important to offer enough time to the consumer and to leave space to talk about problems concerning medications or side effects;
• Mental health providers should ensure that they have received adequate training and/or resources on mental health and safe medication management to provide advice or assistance on these matters;
• A high turn-over of staff in mental health services can hinder compliance;
• Mental health providers need to be aware if Indigenous consumers are taking other medications and ensure that new medications are complementary;
• Treatment regimes should be as simplified as possible and be compatible with existing routines that consumers already have, and may include dispensing medication in Webster Packs or Dosette Boxes;
• In the event that mental health providers suspect that consumers have other undiagnosed conditions that require intervention, referrals need to be make to such services;
• Mental health providers need to be aware if consumers are experiencing any unwanted side effects or have unrealistic expectations concerning the medication;
• Consumers may stop taking medication because they experience no further symptoms and think that they no longer require medication;
• Family members and carers of the consumers should be included in the therapeutic alliance;
• Indigenous mental health workers should be involved and their development fostered whenever possible.