Finding the fit: development of a mental health service for remote Indigenous communities

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It is the intention of the authors to discuss the development of the mental health service of the Far North Queensland Rural Division of General Practice within the communities of Mossman Gorge, Wujal Wujal and Hope Vale. The paper firstly explores the organisational context of this service, then presents the experiences of those implementing the changes in two reflective narratives. Finally, recommendations for future policy are also suggested.

The FNQRDGP was established in 1993 with the aim of integrating general practitioners more fully into the health system and to advance the health and well being of people living in Far North Queensland. The organisations understanding of the determinants of good health and wellbeing are constantly evolving, informed from various sources such as community feedback, government policy, and best practice from within the disciplines represented within the Division.

The Division currently runs a number of programs and incorporates the disciplines of general practice; podiatry; diabetes education; physiotherapy; dietetics and health promotion. Psychology was included in the Division's services in 2001, reflecting the World Health Organization's definition of health as a state of total physical, mental and social well being. All programs are informed by the principles of Comprehensive Primary Health Care.

The authors—the 'social and emotional wellbeing team'—consist of four workers from across two of the programs. Both teams consist of a psychologist and an Indigenous Social and Emotional Wellbeing Practitioner.

Although the social and emotional wellbeing team is employed to address mental health and clinical outcomes within Cape York indigenous communities, the FNQRDGP is aware of the need to align an understanding of clinical mental health with an Indigenous or Bama understanding of mental health (the term Bama is widely used throughout Cape York to mean Aboriginal person, but in both Kuku Yalanji and Guugu Yimithirr, the word simply means 'person' regardless of nationality or race). This paper is about the process of aligning these two understandings and questions the rhetoric implicit in seemingly straightforward concepts such as 'mental health', 'health', 'clinical', 'illness' and 'cure'.

Alarmingly, it has been said that Psychology, perhaps more than any other health discipline "has been implicated in the marginalisation, oppression and dispossession of Indigenous Australians, and this continues at the present time since psychology *as currently practiced* (italics added) is an agent of the dominant culture".[1]

This assertion suggests the need to critically examine discourses of privilege and dominance as a means of combating mechanisms of oppression and racism that may be reproduced in otherwise well intentioned practice.[2] With this in mind, this paper focuses on two narratives based on the critical reflections of two of the team: one from Social and Emotional Wellbeing Practitioner Oriel, a Bama woman with decades of experience as a counsellor and a traditional owner of the Wujal Wujal area; and another from Michael, a non-indigenous male Intern Psychologist working in the mental health field with Bama for the first time.

This paper not only provides these thoughts and processes to the audience, it also marks a stage in the development of the wellbeing team towards a greater understanding of each other's roles and intends to offer suggestions for addressing the impacts of introducing health services into Indigenous communities.

Oriel

As a Bama woman with thirty six years of experience working in North Queensland and Northern West Australia in substance and mental health counselling and community development and management, it has been interesting to take time to consider the development of the FNQRDGP Social and Emotional Well Being Service since the beginning of 2008.

In the communities we service I have seen the well known problems faced by Indigenous Australians throughout Australia such as overcrowding, lack of housing, the continued effects of past and present trauma, money problems, unemployment, underemployment, lack of education, lack of training, poor physical and mental health, suicide, early death, diabetes, crime, abuse in its different form, lack of whole of community control as evidenced by nepotism, a lack of a whole of community spirit, and feelings of worthlessness.

This is particularly frustrating because when mapping the services to one of these communities alone, I estimated a little over eighty government and non-government services were operating. No doubt this mirrors my experience of working with many professional and non-professional people in substance and mental health counselling and finding that each person has a different approach and interpretation on service delivery to Indigenous people.

It has been good for me to assist and support Michael in his psychologist role, as he seemed keen and willing to learn and work with Indigenous people. He was willing to listen to gain some of my knowledge about Wujal Wujal and Hope Vale people as I have been working with both communities for many years.

I believe that the aim of our service is to improve the mental health care of Indigenous people and their families in Hope Vale and Wujal Wujal through providing a culturally appropriate, effective, and efficient health service that provides optimum health outcomes.

To achieve this, I see these as the most important things to do:

- Encourage and assist communities to build their capacity to address mental health issues holistically by helping people with any concern, problem or issue they have. I strongly believe that clinical treatment is not the only way of creating wellbeing and helping a client to start to feel better about themselves. Any intervention service should work across the whole range of prevention, intervention and postvention.

- Build culturally sensitive programs and service delivery that are community managed, directed, and owned in every part of the process. I have worked with the Jalbu Jalbu Warranga women's group in Wujal Wujal for the last two years. This group has assisted the whole community in many ways. We have obtained funding for a market garden based in the community, helped community members to develop and sell art, create a women's centre where women's business can occur, held meetings on issues of concern to the community, found and trained a centre coordinator and created employment opportunities at the centre.

- Develop partnerships with other service providers to provide multi disciplinary care. We are working closely with the Men's Group and Women's Group in Hope Vale, Hope Vale Clinic, Royal Flying Doctors, HACC, Apunipima Cape York Health Council, Mookai Rosie, Mental Health and ATODS

services, Cooktown Multi Purpose Health Service, Wujal Wujal Council, Men's Group and Women's Group in Wujal Wujal

- Work with not just the client but the whole family and the services already working with them. We also will help the client with any situation they are troubled by, for example going to Court to support the client and alleviate some of stress and anxiety on them and their family.

Michael

Changing

I want to begin by detailing the ongoing changes I have made whilst working with Bama people in addressing their social and emotional wellbeing. This process began around eighteen months ago when I started in this psychologists position and is still very much ongoing. It occurs to me that one indicator of the changes I have made is witnessed in the presentation of this paper as a narrative. Prior to having these experiences, I would have been very concerned about presenting a paper where the results could only be described in words instead of design descriptions, p scores, confidence intervals and the other tools of psychological enquiry. That I now feel comfortable in doing so indicates the degree of change I have made.

When I started in this position, it became apparent that there were several factors that would potentially influence, or could be used to influence my service provision. These included:

- that my organisation was committed to using the principles of Comprehensive Primary Health Care (CPHC)

- that the existing service model was culturally embedded in terms of reporting and funding requirements as it valued quantitative occasions of service over the qualitative suitability of the service

- existing mental health services in these communities, that despite being well intentioned, reinforced oppressive hegemonies

- that these mental health services co-existed with general health services that did likewise

- that the service model had potential to be flexible and responsive

- that the client population had both strengths and challenges.

When considering where to start building an appropriate and effective service, I was comforted to find that it was considered best practice under CPHC models to ease into a community, establish relationships, get to know community dynamics, and map existing services.[3,4,5,6] This breathing space led to a decision to critically reflect on factors relating to myself and my professional frameworks as the point at which to start.[7] Whilst this critical reflection had been encouraged at University, I had found in the years since leaving that this was not necessarily valued in the workplace where time constraints, reporting requirements and the need for quick and observable results seemed preferred.

Psychology offered some assistance in this process, with areas such as community psychology, humanistic psychology, and the philosophical underpinnings of liberation psychology providing guidance. I also found the small but passionate literature on Indigenous Australian psychology (see [8, 9, 10, 11] for examples) had a great deal to offer. Explorations of other disciplines were also invaluable, especially anthropology, as well as social work, nursing, sociology and history.

Deconstructing and reconstructing these related frameworks was both an exhilarating and frustrating experience: exhilarating as I saw a world open up before me, and frustrating because I realised that I could never go to work in a community and relax. To be effective I would have to shed the easiness of existing in my own cultural milieu and work very hard at understanding and operating within another.

As well as text based research, when in the community I found the insights afforded by becoming an amateur Anthropologist—incorporating basics such as cultural relativity, asking questions when appropriate, doing lots of watching as a participant observer, and making an effort to accept things that were outside of my understanding of reality were invaluable.

Luckily, I also found it possible to incorporate knowledge from my psychological training as well. It was easy to see parallels between the viewpoints: for example, if a person told me they were receiving spiritual visits from deceased loved ones I could see them analogous to sleep-cycle hallucinations or random neural activity (especially where all too common hearing problems or nervous system damage were present). I could also find other parallels, such as physical illness attributed to Dumboon (black magic) and the clinical presentation of psychosomatic disorders.

Less reassuringly however, I was aware that whilst these biomedical understandings explain the mechanism of such experiences very well, they don't explain the meanings, the "why me" and "why now" of such experiences, whereas perhaps Bama understandings came closer.

I eventually came to understand my philosophy and approach as one of 'epistemological neutrality', where all situations are approached with as little of my pre-existing beliefs, values and knowledge as I can manage. In a way this parallels the philosophical basis of humanistic psychology which emphasises the need to enter into value systems, however this also requires entering into belief and knowledge systems as well. Probably standard fare for an anthropologist, but not so for an inexperienced white psychologist working in an indigenous community in Australia!

A review of the literature also made me aware of the need to create an organisational environment of cultural safety[12] to facilitate my learning and create effective service delivery to clients. I saw the best way to do this as communicating to staff and clients alike several messages: I am not an expert, I am wanting to work collaboratively, I will respect boundaries, and I will accept the validity of the information you may give me.

As well as being the catalyst for respectful and effective working relationships, I hoped that this would lead to staff and community members vouching for me. The vouching system refers to the practice common in indigenous society of a potential client seeking an assessment of the practitioners personality, style of interaction and effectiveness from third parties such as friends or relatives.[1]

In summary, this part of my journey has been characterised by an adoption of what I have termed epistemological neutrality, a process aided by text based and experiential research, and created by a questioning and expansion of my understandings of reality. This has been a transformative experience for me as a person, losing old sureties whilst finding new ones and leaving me with more questions than answers. Happily though, I at least feel closer to achieving effective practice with Bama thanks to this process.

What these changes have brought

So far I have had both good and bad experiences in this role. I have gone away from working in these communities at different times feeling variously competent, incompetent, frustrated, content, eager to work with the person again, and wanting to hide away back in my office.

I have found some of mainstream psychology's staples such as Cognitive Behavioural Therapy both useful and dismally inadequate. I have had therapeutic relationships that have been effective over many visits and then (in my initial appraisals) perplexingly ceased. I now understand these instances to be a product of polychronic or 'rubber-band' time[13] where the problem no longer exists in the here-and-now, so doesn't need to be addressed in the here-and-now either. Psychometric instruments too have great problems with validity in this context, hence we have begun work on a set of behavioural indicators of psychosocial functioning valid for use in these communities.

I have certainly learnt the importance of flexibility and responsiveness. Across all communities we take referrals from all sources: clients, service providers, and third parties (usually family members) and have no set criteria for acceptance of the referral. We operate essentially from our vehicle, doing home visits, meeting by the river or wherever requested.

In one community we are very busy with a clinical load and health promotion activities. In another community, we have found that the internal structures (such as the elders justice group and the Clinics Health Workers) take care of the majority of issues that community members experience. Here, instead of focusing on community members, we have instead helped resident service providers with psychological support, undertaken health promotion activities and in Oriels case, chaired the community women's group. Yet another community has so far been very hard to engage, and here an outcome remains to be seen.

From a practice perspective, epistemological neutrality has helped me to work with clients in situations such as these:

- where the cause of Type 2 Diabetes Mellitus is attributed to Dumboon

- where illness is exacerbated by non-compliance with medication due to the implication of Dumboon as the causative agent

- where polychronic time impacts on preventative behaviour change, treatment compliance, and addressing problematic or self-defeating behaviour

- where Dumboon is used as a means of domestic violence

- where I am working concurrently, though not together with a traditional doctor.

I have found the following three steps have increased my effectiveness in working with these issues:

- Firstly, it is necessary to have an awareness of these issues. Establishing relationships with community members or hiring local people on staff can provide access to this information. I have found that these two processes happen simultaneously as people provide me with information and then watch to see what I do with it.

- The second step is to work within the limits of the knowledge that will be shared. It is enough to have just some idea of what happens and why. I have encountered several barriers to gaining in depth knowledge: community member/non-member status, Bama/non-Bama, and gender. Indeed, during the preparation of this paper, Oriel mentioned that whilst I knew the identity of male traditional doctors, I had not been told of the females occupying this role. I had naively (and admittedly misogynistically) assumed that there were only males doing this job!

- The third step is to acknowledge these factors with clients. I have found clients will not discuss their concerns regarding Dumboon in great detail with me, however I reinforce with clients that this is a valid path for them to follow in addressing their problems. Some clients may ask for my opinion

(seemingly because of my 'expert' status) so I suggest that it could be as effective as other treatments and that my service may work well in tandem. So far I have found passive resistance to the idea of me being a referral point to traditional doctors so have not actively pursued it.

Working holistically

In order to work holistically in these communities as per the CPHC approach, we have been working on other salutogenic initiatives outside of our clinical work.

We are in the early research and development stages of creating an empowerment model based on exploring the current position of Indigenous people in Australian society from a social constructionist viewpoint. Many precedents for this approach exist, such as the feminist and LGBTI approaches to empowerment, and the work of Paulo Friere.[14]

Currently this is proceeding slowly as we have identified several areas as problematic. First and foremost are our own shortcomings: I have trained as a psychologist, Oriel has many years experience in counselling and community development. Neither of us are sociologists, political scientists or indeed teachers and as such progress is slow on creating a framework for delivery.

Also, we are aware that much of what could be explored in this is very 'white' knowledge. It tends toward abstract rather than concrete, written rather than demonstrated, and western understandings of time and process. We fear these are likely to create barriers for engaging many of our clients, and overcoming this is proving to be challenging indeed.

We have also began to undertake a process of reorienting all of our organisations health programs toward a meaningful fit with their clients. Amongst work being undertaken for this is the gathering of a body of Bama knowledge necessary for effective clinical practice, upskilling clinical staff in this, and ensuring the sustainability of these initiatives by writing them into organisational policy and procedure.[15]

Conclusion

As stated at the beginning, this paper has been written not to provide expert advice, but rather to add another piece to the jigsaw of Indigenous health provision. The paper shows one possible 'how' rather than 'the what'. We have deliberately not presented outcomes as we believe that we are yet to see long term meaningful changes, and we are prepared to wait for several more years before feeling confident in analysing and commenting on these. We have mentioned successes along the way, such as Oriels success with the Jalbu Jalbu group and the clinical successes that indicate that we are on the right path at least.

To make policy recommendations as requested of all contributors to this conference, we would wholeheartedly recommend the following:

- That there is a reorientation by all health services and individual providers to the principles of Comprehensive Primary Health Care. This model gives the freedom from older and demonstrably ineffective paradigms to tailor health care to the needs of Indigenous communities.

- That all health services and providers actively seek to create a body of knowledge of contemporary Indigenous health knowledges, beliefs and practices.

- That all health services and providers implement this knowledge in practice: creating policy and procedure, empowering practitioners, and engaging communities under the models they create.

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