Chapter 23: Australian Aboriginal and Torres Strait Islander Psychiatry

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Social and Emotional Well-Being

The closest word for 'health' in Aboriginal and Torres Strait Islander languages translates best as "wellbeing", though the equivalent word often has a much broader meaning. For example, the word 'punyu', from the language of the Ngaringman from the Northern Territory, is sometimes translated as wellbeing, but the word also encompasses 'person' and 'country' in its meaning. It is also associated with being strong, happy, knowledgeable, socially responsible, beautiful, clean and safe.

Social and emotional wellbeing is the basis for understanding concepts of physical and mental health for Aboriginal and Torres Strait Islander Australians. It is an holistic approach to health that encompasses the importance of connection to land, culture, spirituality and ancestry, and how these affect the wellbeing of the individual and the community as a whole (Gee et al., 2014). Western medicine tends to understand the disease process by emphasizing the natural history of the disease within the individual. However, for Aboriginal and Torres Strait Islander people, mental health is approached from the broader perspective of social and emotional wellbeing.

The concept recognises that a person's wellbeing is influenced by key social determinants of health, such as stable housing, employment opportunities and access to other societal benefits and privileges. For Aboriginal and Torres Strait Islander people these social determinants have been shaped by major historical and contemporary social forces such as government policies, institutional racism, and the effects of colonisation.

Jiman/Bundjalung woman Professor Judy Atkinson explains the centrality of land and country to Aboriginal and Torres Strait Islander ideas of identity and wellbeing. "Land is a story place. Land holds the stories of human survival across many generations. Land shapes people, just as people shape their countries". Far from being an uninhabited wilderness, as conceived of by Europeans and named 'Terra Nullius', the land called Australia "is a moral sphere, the seat of life and emotions, and a place of the heart". "The land grew the people and people grew the country" (Atkinson, 2002).

Social and emotional wellbeing is not the same as mental health and mental illness, but they are related concepts. They can interact and influence each other. You can have good social and emotional well-being and still have a mental illness. (Department of the Prime Minister and Cabinet, 2017).

Domains of Social and Emotional Wellbeing

In the diagrammatic representation below (Figure 23.1), the self is pictured as being surrounded by 7 overlapping domains that are sources of wellbeing and connection. The domains support a strong and positive Aboriginal and Torres Strait Islander Australian identity. The model also acknowledges the historical, political and societal forces that have shaped, and continue to shape, the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians (Gee et al., 2014).

The 7 key domains are:

1. **Connection to body** which concerns physical health; feeling strong and healthy and being able to physically participate as fully as possible in life.
2. **Connection to mind and emotions** which concerns mental health; the ability to manage thoughts and feelings. Maintaining positive mental, cognitive, emotional and psychological wellbeing is fundamental to an individual's overall health.
3. **Connection to family and kinship** These connections are central to the functioning of Aboriginal and Torres Strait Islander Australian societies. Strong family and kinship systems can provide a sense of belonging, identity, security, and stability for Aboriginal and Torres Strait Islander people.
4. **Connection to community** which provides opportunities for individuals and families to connect with each other, support each other and work together.
5. **Connection to culture** helps maintain a secure sense of cultural identity by participating in practices associated with cultural rights and responsibilities.
6. **Connection to Country** helps to underpin a person's identity and a sense of belonging. Country refers to an area on which Aboriginal and Torres Strait Islander people have a traditional or spiritual association. Country is viewed as a living entity that provides nourishment for the body, mind and spirit.
7. **Connection to spirituality and ancestors** provides a sense of purpose and meaning. The mental health and emotional wellbeing of Aboriginal and Torres Strait Islander Australians can be influenced by their relationship with traditional beliefs and metaphysical worldviews.

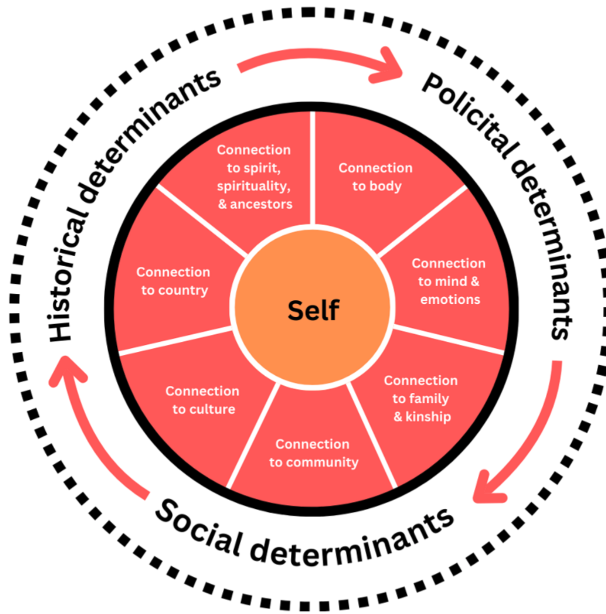


Figure 23.1. Overlapping domains that are sources of wellbeing and connection. Adapted from Gee et al. (2014).

Epidemiology of Psychological Distress and Mental Disorders in Aboriginal and Torres Strait Islander Australians

A Definition of Good Mental Health

At an individual level, good mental health can be defined as a positive state of wellbeing in which a person can manage their thoughts and feelings to cope with the normal stressors of life and reach their potential. For many Aboriginal and Torres Strait Islander Australians, good mental health goes beyond this. It indicates feeling a sense of belonging, having strong cultural identity, maintaining positive interpersonal relationships, and feeling that life has purpose and value (Dudgeon et al., 2014).

Life Expectancy

Life expectancy and deaths are widely used as indicators of population health. Given current mortality patterns, Aboriginal and Torres Strait Islander males

born in 2015–2017 can expect to live 71.6 years, and Aboriginal and Torres Strait Islander Australian females 75.6 years, which is 10 years less than for the general population (Australian Bureau of Statistics, 2019). In general, life expectancy is lower in remote areas, with Aboriginal and Torres Strait Islander males and females living in major cities expected to live around 6 years longer than those living in remote and very remote areas.

Causes of Death

When considering causes of death, in 2020, intentional self-harm was the fifth leading cause of death among Aboriginal and Torres Strait Islander Australians (behind coronary heart disease, diabetes, chronic respiratory diseases, and cancers of the airways), suggesting a high burden of psychological distress in the Aboriginal and Torres Strait Islander community (Australian Bureau of Statistics, 2022).

Burden of Disease

The burden of disease describes the number of years of healthy life lost, either through chronic ill health or premature death. Almost half of the burden of disease in Aboriginal and Torres Strait Islander Australians is due to modifiable risk factors (Australian Institute of Health and Welfare, 2022b). Mental illness and substance use as a disease group is by far the single biggest causal group of burden of disease for Aboriginal and Torres Strait Islander Australians (Australian Institute of Health and Welfare, 2022b). This disease group accounts for 20% of the total burden of disease, overtaking cardiovascular disease in recent years. This is highest in the age group late childhood to age 44. When considering individual diseases, 4 of the 5 diseases with the highest burden among Aboriginal and Torres Strait Islander Australians in 2018 were mental health related; anxiety disorders (accounting for 5.3% of the burden of disease), suicide and self-inflicted injuries (4.6%), alcohol use disorders (4.4%) and depressive disorders (4.3%).

Suicide

Data from 2016–2020 show that the rate for suicide of Aboriginal and Torres Strait Islander Australians is almost twice the rate of non-Indigenous Australians, with the differences being greater for people aged under 45 (Australian Bureau of Statistics, 2022). Suicide was the fifth leading cause of death among Aboriginal and Torres Strait Islander Australians in 2020, accounting for 5.5% of all deaths. It was also the leading cause of death for Aboriginal and Torres Strait Islander children aged 5–17 (Australian Bureau of Statistics, 2022). By comparison, suicide was the 14th leading cause of death for the general Australian population (1.9% of all deaths).

Rates of Mental Distress and Mental Illness

There are two main sources of information for estimating rates of psychological distress and mental illness. The first source is the National Aboriginal and Torres Strait Islander Health survey, which is conducted by the Australian Bureau of Statistics periodically (Australian Bureau of Statistics, 2019). The second is the Mayi Kuwayu study, which has been created by and for Aboriginal and Torres Strait Islander peoples and in response to the general community's perceived lack of understanding of the importance of Aboriginal and Torres Strait Islander culture and its link to wellbeing (Gee et al., 2014). Interestingly, the results of the two studies are similar.

Rates of Psychological Distress

In the 2018-2019 National Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2019), over two-thirds (66%) of Aboriginal and Torres Strait Islander Australian adults reported some degree of psychological distress. The rate was higher among males (70%) than females (63%). An estimated 31% reported high or very high levels of psychological distress in the last 4 weeks. The number reporting high or very high levels of psychological distress has increased compared to previous surveys. Those aged 45 to 54 years were most likely to report 'high or very high' levels of psychological distress. The Mayi Kuwayu study suggests that up to half of the psychological distress experienced is caused by discrimination.

Mental Disorders

Mental disorders are diagnosed according to standardized criteria based on internationally standardized diagnostic tools such as the DSM-5-TR (American Psychiatric Association, 2022). It is important to note that the main diagnostic tools used in population surveys in Australia have not been validated for Aboriginal and Torres Strait Islander Australian populations. However, this notwithstanding, in the 2018–19 survey, an estimated 24% of Aboriginal and Torres Strait Islander Australians reported having a diagnosed mental health or behavioural condition with a higher rate among females (25%) than males (23%). More than one in 10 individuals reported having an anxiety disorder (16.5%) or depression (13.3%) (Australian Bureau of Statistics, 2019).

Within the group of mental and substance use disorders (that is, considering all mental disorders as accounting for 100%) the leading disorders were anxiety disorders (23%), alcohol use disorders (19%), depressive disorders (19%), drug use disorders (excluding alcohol) (9%) and schizophrenia (7%) (Australian Institute of Health and Welfare, 2022b).

Drugs and Alcohol Use

Hazardous alcohol and substance use is a major modifiable risk factor that contributes to the burden of disease. Hazardous substance use occurs at approximately twice the rate for Aboriginal and Torres Strait Islander Australians when compared to the general population (Australian Institute of Health and Welfare, 2011). In a 2008 survey by AIHW, 23% had used an illicit drug recently and 4 out of 10 had used an illicit drug in the last 12 months. Cannabis and amphetamines were the most commonly used drugs.

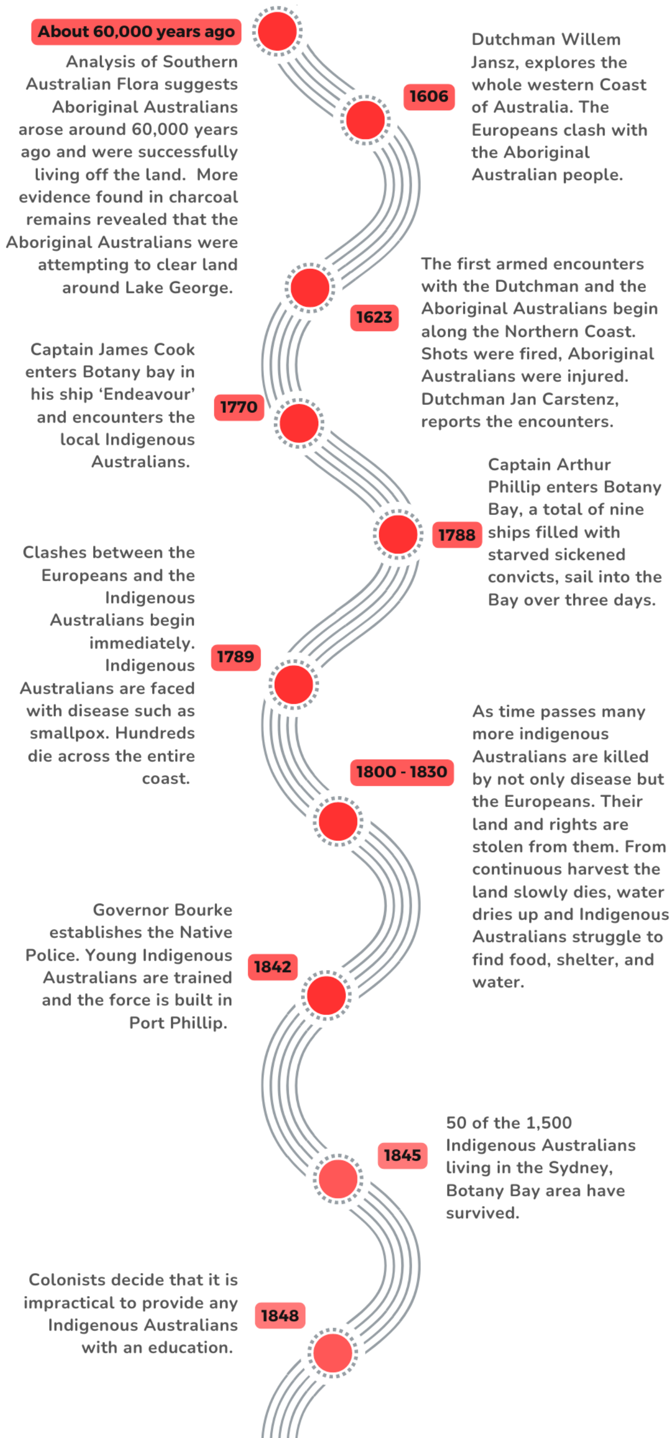
Cigarette smoking occurs in over 40% of Aboriginal and Torres Strait Islander Australians which is twice the general population rate (Australian Institute of Health and Welfare, 2011). With regard to alcohol use, whilst the overall rate for Aboriginal and Torres Strait Islander Australians is lower than the general population rate, patterns of hazardous use (including binge pattern use and chronic use) are greater, especially in the age 16-24 (Australian Institute of Health and Welfare, 2011).

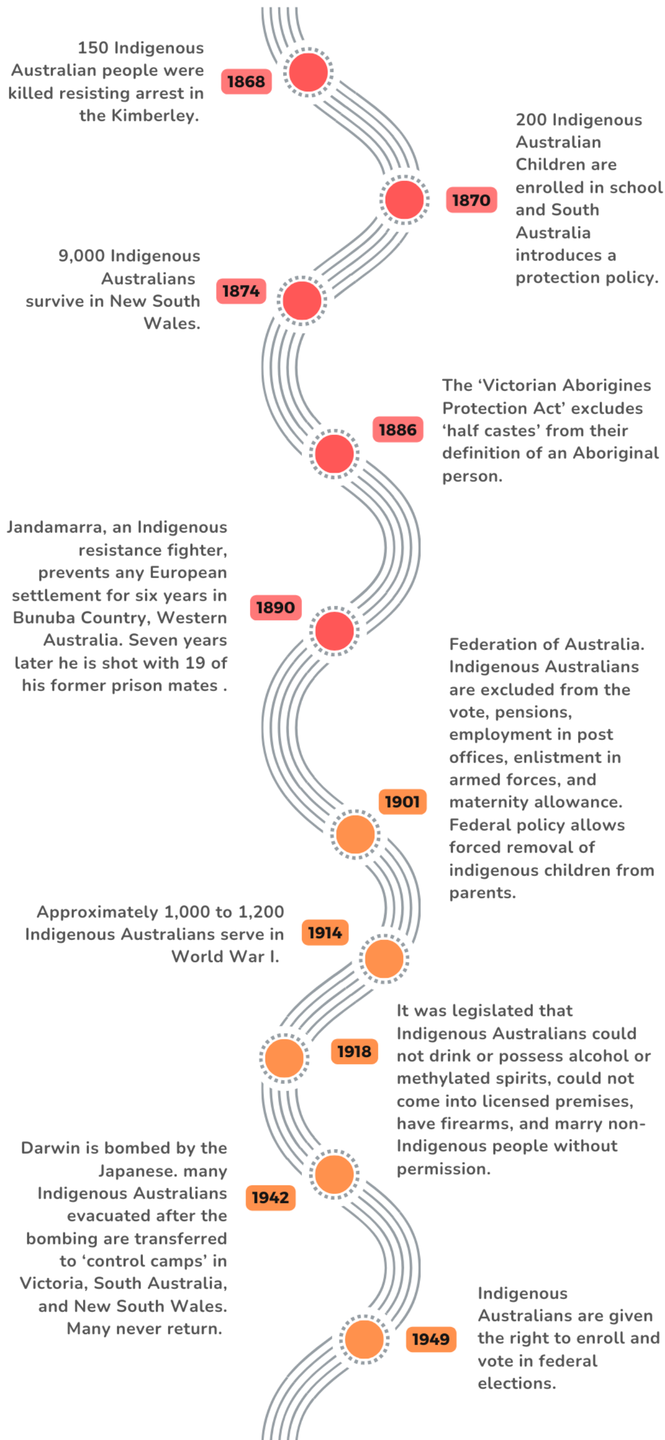
Hospital Use

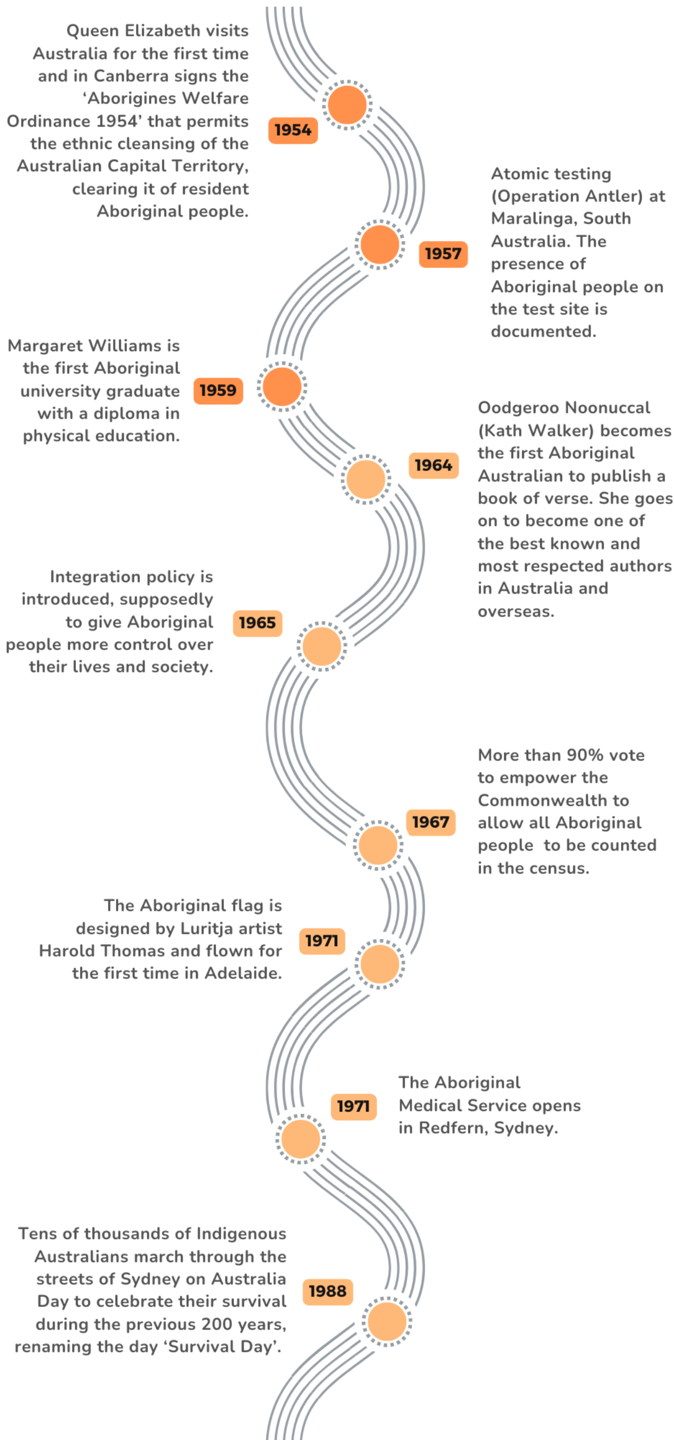
Hospitalization rates can be used as a proxy measure for psychiatric morbidity in the community. In the period 2020-2021, hospitalizations for mental and behavioural disorders in Aboriginal and Torres Strait Islander Australians accounted for 8.4% of all hospitalizations for Aboriginal and Torres Strait Islander Australians, of which 0.5% were for self-inflicted injury (Australian Institute of Health and Welfare, 2022a). The rates of admission were approximately twice the rate for psychotic illnesses compared to the general population and more than 1.2 times the rate for depressive disorders, suggesting greater severity of illness.

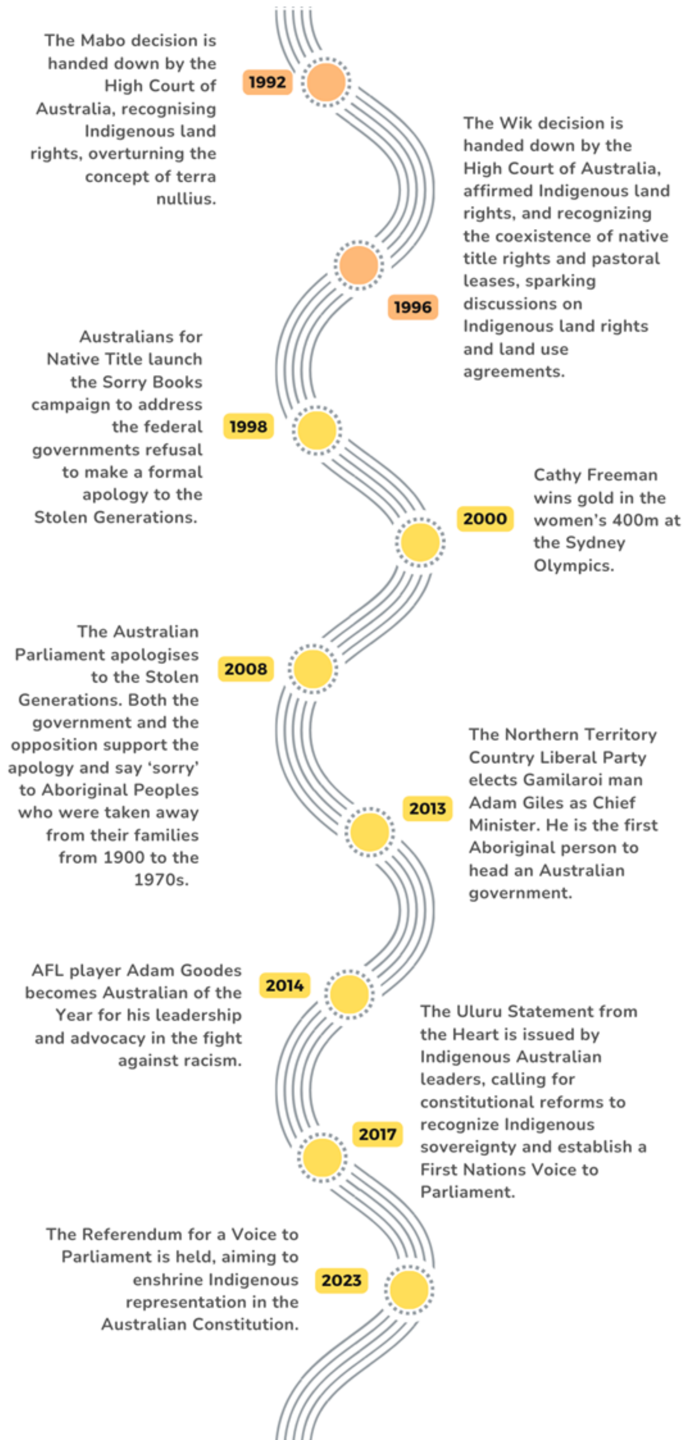
History Timeline

The timeline on the following pages provides a snapshot of some key social and political events that have shaped the welfare of Aboriginal and Torres Strait Islander Australians in the post-colonial era. It highlights the traumatic nature of the historical interactions between Aboriginal and Torres Strait Islander Australians and their European colonizers.


About 60,000 years ago
Analysis of Southern Australian Flora suggests Aboriginal Australians arose around 60,000 years ago and were successfully living off the land. More evidence found in charcoal remains revealed that the Aboriginal Australians were attempting to clear land around Lake George.
1606
Dutchman Willem Jansz, explores the whole western Coast of Australia. The Europeans clash with the Aboriginal Australian people.
1623
The first armed encounters with the Dutchman and the Aboriginal Australians begin along the Northern Coast. Shots were fired, Aboriginal Australians were injured. Dutchman Jan Carstenz, reports the encounters.
1770
Captain James Cook enters Botany bay in his ship 'Endeavour' and encounters the local Indigenous Australians.
1788
Captain Arthur Phillip enters Botany Bay, a total of nine ships filled with starved sickened convicts, sail into the Bay over three days.
1789
Clashes between the Europeans and the Indigenous Australians begin immediately. Indigenous Australians are faced with disease such as smallpox. Hundreds die across the entire coast.
1800 - 1830
As time passes many more indigenous Australians are killed by not only disease but the Europeans. Their land and rights are stolen from them. From continuous harvest the land slowly dies, water dries up and Indigenous Australians struggle to find food, shelter, and water.
1842
Governor Bourke establishes the Native Police. Young Indigenous Australians are trained and the force is built in Port Phillip.
1845
50 of the 1,500 Indigenous Australians living in the Sydney, Botany Bay area have survived.
1848
Colonists decide that it is impractical to provide any Indigenous Australians with an education.


150 Indigenous Australian people were killed resisting arrest in the Kimberley.
1868
1870
200 Indigenous Australian Children are enrolled in school and South Australia introduces a protection policy.
9,000 Indigenous Australians survive in New South Wales.
1874
1886
The 'Victorian Aborigines Protection Act' excludes 'half castes' from their definition of an Aboriginal person.
Jandamarra, an Indigenous resistance fighter, prevents any European settlement for six years in Bunuba Country, Western Australia. Seven years later he is shot with 19 of his former prison mates .
1890
Federation of Australia. Indigenous Australians are excluded from the vote, pensions, employment in post offices, enlistment in armed forces, and maternity allowance. Federal policy allows forced removal of indigenous children from parents.
1901
Approximately 1,000 to 1,200 Indigenous Australians serve in World War I.
1914
1918
It was legislated that Indigenous Australians could not drink or possess alcohol or methylated spirits, could not come into licensed premises, have firearms, and marry non-Indigenous people without permission.
Darwin is bombed by the Japanese. many Indigenous Australians evacuated after the bombing are transferred to 'control camps' in Victoria, South Australia, and New South Wales. Many never return.
1942
1949
Indigenous Australians are given the right to enroll and vote in federal elections.


Queen Elizabeth visits Australia for the first time and in Canberra signs the 'Aborigines Welfare Ordinance 1954' that permits the ethnic cleansing of the Australian Capital Territory, clearing it of resident Aboriginal people.
1954
Atomic testing (Operation Antler) at Maralinga, South Australia. The presence of Aboriginal people on the test site is documented.
1957
Margaret Williams is the first Aboriginal university graduate with a diploma in physical education.
1959
Oodgeroo Noonuccal (Kath Walker) becomes the first Aboriginal Australian to publish a book of verse. She goes on to become one of the best known and most respected authors in Australia and overseas.
1964
Integration policy is introduced, supposedly to give Aboriginal people more control over their lives and society.
1965
More than 90% vote to empower the Commonwealth to allow all Aboriginal people to be counted in the census.
1967
The Aboriginal flag is designed by Luritja artist Harold Thomas and flown for the first time in Adelaide.
1971
The Aboriginal Medical Service opens in Redfern, Sydney.
1971
Tens of thousands of Indigenous Australians march through the streets of Sydney on Australia Day to celebrate their survival during the previous 200 years, renaming the day 'Survival Day'.
1988


1992
The Mabo decision is handed down by the High Court of Australia, recognising Indigenous land rights, overturning the concept of terra nullius.
1996
The Wik decision is handed down by the High Court of Australia, affirmed Indigenous land rights, and recognizing the coexistence of native title rights and pastoral leases, sparking discussions on Indigenous land rights and land use agreements.
1998
Australians for Native Title launch the Sorry Books campaign to address the federal governments refusal to make a formal apology to the Stolen Generations.
2000
Cathy Freeman wins gold in the women's 400m at the Sydney Olympics.
2008
The Australian Parliament apologises to the Stolen Generations. Both the government and the opposition support the apology and say 'sorry' to Aboriginal Peoples who were taken away from their families from 1900 to the 1970s.
2013
The Northern Territory Country Liberal Party elects Gamilaroi man Adam Giles as Chief Minister. He is the first Aboriginal person to head an Australian government.
2014
AFL player Adam Goodes becomes Australian of the Year for his leadership and advocacy in the fight against racism.
2017
The Uluru Statement from the Heart is issued by Indigenous Australian leaders, calling for constitutional reforms to recognize Indigenous sovereignty and establish a First Nations Voice to Parliament.
2023
The Referendum for a Voice to Parliament is held, aiming to enshrine Indigenous representation in the Australian Constitution.

Inter-Generational Trauma and Determinants of Health

The psychological impacts of trauma are explored in detail in a separate chapter of this book and is essential pre-reading for this chapter. Going beyond this, given the seismic shift in the world of Aboriginal and Torres Strait Islander Australians that occurred with the dawn of the colonial era, it is important to understand the impacts of these historical forces on Aboriginal and Torres Strait Islander Australians as an entire race.

The encounter between Australia's Aboriginal and Torres Strait Islander peoples and European colonizers has been described as an asymmetrical collision of cultures with the burden of trauma almost exclusively confined to Aboriginal and Torres Strait Islander Australian individuals, families and communities (Hunter, 1998). The traumatic events can be broadly divided into two phases; the phase of physical violence, beginning in the early colonial period, and marked by mass extinctions through killings, the introduction of foreign diseases, and starvation due to the forced removal of lands and food sources. The second phase is one of structural violence, in which state and federal government policies were enacted with the underlying philosophy of crude social Darwinism, that is the belief that Aboriginal and Torres Strait Islander peoples were an inferior race of humans that would inevitably die out. These policies had two aims: assimilation, and the elimination of Aboriginal and Torres Strait Islander culture, including its history and language. As examples, such policies allowed for segregation of Aboriginal and Torres Strait Islander people into settlements, the forced removal of children from their families (the 'stolen generation') and sanctioned slavery.

Trauma that is experienced by an entire group or race of people as a whole is not unique to Aboriginal and Torres Strait Islander Australians. It is an experience common to many First nations peoples across the world. There are also many studies of war-related trauma showing the intergenerational transmission of trauma through the effects on family structure and functioning (Harkness, 1993).

There are numerous terms which essentially describe the same process. The terms 'collective trauma', 'transgenerational trauma' and 'intergenerational trauma' are synonyms that describe the phenomenon of trauma that impacts universally throughout a group of people, and which then reverberates from one generation to the next within that group, so that the effects are felt for many generations to come. Although these experiences may be more difficult to describe at the individual level, the trauma results from experiences that impact a whole community, and is felt by the community. For Aboriginal and Torres Strait Islander people these terms describe the impact of colonisation, dislocation, and

discrimination affecting Aboriginal and Torres Strait Islander Australian individuals, families, and communities (Atkinson et al., 2014).

According to Erikson (1994), the impact of collective trauma is a 'blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community' (p. 233), which effectively renders the group powerless and deprived of the communal scaffolding, structures, and systems to navigate traumatic situations (Menzies, 2019).

Professor Helen Milroy (Australian Institute of Health and Welfare, 2016) offers a comprehensive description about the multi-layered effects of intergenerational trauma on Aboriginal and Torres Strait Islander Australians, displayed in the box below.

Professor Helen Milroy on intergenerational trauma

"The transgenerational effects of trauma occur via a variety of mechanisms including the impact of attachment relationships with care givers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from the extended family, culture, and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effects of the original trauma which a parent or care giver has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity, and early mortality."

A central pathogenic mechanism in transgenerational trauma is the disruption to the building blocks of stable attachment formation, those being a stable and secure home environment. Menzies argues that due to practices of removal from family and relocation to unfamiliar environments there is loss of basis for developing healthy and sustainable family structures (Menzies, 2019).

"Forced separation and assimilation have meant that significant numbers of Aboriginal people experienced the destruction of the family unit, the dislocation from home and community to unfamiliar places with unfamiliar people, because as children they were denied what is now considered to be a fundamental and universal human right: the right to grow up in a family environment, in an atmosphere of happiness, love and understanding".

When considering the impact of trauma within Aboriginal and Torres Strait Islander communities, it is important to engage with communities and to learn about and acknowledge some of the experiences that have left their legacy. This journey of 'truth telling' is part of the process of healing. The story in the text box below provides an illustration of collective trauma. This story is from the Brewarrina community (Ngemba Country). The story is from an Aboriginal and Torres Strait Islander elder from that area who knew some of the old tribal men when he was young, and he didn't know why they had a pronounced limp. When he asked about it this is what he was told.

When settlers first came to the Brewarrina region, they invaded and occupied existing traditional lands for farming purposes. Due to the clash of cultures between the traditional custodians and the settlers, there was much disharmony between these groups. Over time the settlers stole Aboriginal women and girls as they needed servants to look after the house duties until their settlements were established, and they could then encourage colonial women to relocate and start families and support the settlers.
Once the Aboriginal women and girls were stolen, the Aboriginal men would come to the properties at night and leave with the Aboriginal women and girls. The Aboriginal groups would then travel away, and the settlers had no one to do the house duties. This was an ongoing problem for the settlers. The traditional owners could travel across land very fast and were able to avoid being found by the settlers.
To reduce the problem of losing Aboriginal women and girls, the settlers then captured some of the Aboriginal men looking to free their family members, and they would cut one of their Achilles tendons so that the men could not travel very far on foot, and they could not leave the area with their families. Once this happened the Aboriginal men would be easily caught if they tried to leave, and the Aboriginal women and girls were able to be kept as servants.

Atkinson et al. (2014) argue that western diagnostic classification systems are not adequate for describing the impact of trauma in First nations Australians, and therefore may not be helpful in guiding management. Mental illness diagnoses such as PTSD do not conceptually capture the levels of chronic, ongoing stress that Aboriginal and Torres Strait Islander peoples experience in their everyday lives. The impacts of trauma are cumulative and so pervasive that they are too numerous to mention. It is virtually impossible to identify and overcome a single source of stress. Individuals, families and communities continue to feel so disempowered and let down by Australia's laws, institutions and societal attitudes that they have entered a state of learnt helplessness, in which they have learnt not to hope for change or improvement.

Key Determinants of Health

Health outcomes for Aboriginal and Torres Strait Islander peoples are influenced by a complex interaction of environmental (non-medical) factors, behaviours and biological factors. These factors are called the 'determinants of health', and they can be barriers or enablers to health and wellbeing (Australian Indigenous HealthInfoNet, 2024).

An important aspect of this interaction is the role played by the key social determinants of income, education, and employment. According to the World Health Organisation, the social conditions in which people are born, live and work is the single most important determinant of good health or ill health (Australian Institute of Health and Welfare, 2016). As factors that affect health, social determinants can be seen as 'causes of the causes'—that is, as the foundational determinants which influence other health determinants.

These and other related indicators of material wealth combine to determine one's socioeconomic position within the wider community. The social determinants of health related to socioeconomic position help to explain both the gaps in the average health status of Indigenous and non-Indigenous Australians, and the wide variation observed in the health outcomes within the Aboriginal and Torres Strait Islander Australian population.

Other key determinants include:

1. **Environmental factors** including access to safe water supply, good waste management, food security, caring for country, personal hygiene, and containment of communicable diseases.
2. **Cultural factors** such as exposure to institutional racism (for example in the judicial system), discrimination, and the ongoing effects of colonisation.
3. **Community capacity** factors that promote strong communities. These include family safety, child protection, interactions with criminal justice, governance, access to transport, and digital services. On some of these indices, Aboriginal and Torres Strait Islander Australians are grossly disadvantaged. For example, Aboriginal children are removed from their families at 7 times the rate of non- Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander people are imprisoned at a rate of 13 times the national rate (Australian Bureau of Statistics, 2023).

4. **Health behaviours**: healthy eating (which is dependent on access to healthy fresh food), physical activity, smoking, substance use and immunisation.

Assessment and Diagnosis

While assessment and diagnosis are important tools for mental health professionals, their misuse can perpetuate racial and cultural stereotypes, and be used as a method of cultural control. Much of the suspicion that Aboriginal and Torres Strait Islander people have regarding these processes derives from its political nature. In the context of the traumatic history of European impact on Aboriginal and Torres Strait Islander Australians, it is easy to understand the caution that most Aboriginal and Torres Strait Islander people have about psychiatric assessment and diagnosis. Psychiatric assessment has been deeply rooted in the power differential between the coloniser and colonised. It is important that mental health practitioners be careful not to further pathologize Aboriginal and Torres Strait Islander people in their assessment and diagnostic process (Adams et al., 2014).

The RANZCP (Royal Australian and New Zealand College of Psychiatrists) highlights the important role psychiatrists can play in breaking down myths and stereotypes about Aboriginal and Torres Strait Islander people, and in changing societal attitudes (Royal Australian New Zealand College of Psychiatrists, 2014). The college has articulated some key principles to guide mental health practice:

- Adapt Western-style individualistic models of diagnosis and assessment to accommodate the broader conceptual frame of Aboriginal and Torres Strait Islander well-being, incorporating the importance of land, spirituality and culture.
- Recognize the role of trauma, racism, marginalization, mainstream ignorance and hostility, and its impact on Aboriginal and Torres Strait Islander mental health and burden of distress.
- The workforce should adopt an Aboriginal and Torres Strait Islander frame of reference and be skilled in cultural competence.
- Caution must be taken against perpetuating ongoing trauma in our practices of assessment and care.
- Practice in partnership with Aboriginal and Torres Strait Islander people and work with respect and dignity.
- Recognize and seek out culturally relevant models of care as alternatives to Western biomedical models of care.

With these principles in mind, the challenge is to conduct diagnostic assessments in a culturally sensitive manner, ideally using tools that have been devised and validated for culturally diverse Aboriginal and Torres Strait Islander populations. Western diagnostic assessment is generally individualistic and symptom-focused, aiming at syndromal identification. Furthermore, it has been criticized for its focus on deficits,

rather than strengths, and a tendency to pathologize the ordinary. This increases the risk of discrimination and stigmatization.

The most internationally recognized and commonly-used diagnostic tools DSM-5 and ICD-11, have attempted to improve the cultural sensitivity of their diagnostic instruments. The DSM-5-TR now includes guidelines for cultural assessment of people from diverse cultural backgrounds, which separates out the cultural elements from the context of psychiatric diagnosis. It identifies some key dimensions to be explored in any assessment process. These include cultural identity, cultural explanations of the illness, cultural factors associated with psychosocial functioning, and cultural elements of the relationship between the client and the practitioner. The DSM-5-TR now offers the 'Cultural Formulation Interview', which can be used to assist clinical understanding and decision making, not merely diagnostic process (American Psychiatric Association, 2022).

The Practitioner-Client Relationship

It is important to consider the power differential inherent in the relationship between the assessor and the person being assessed and how this may impact on presentation and interpretation. The national practice standards for the mental health workforce 2013 (Department of Health and Aged Care, 2013), dictate that all practitioners must undergo training in cultural competency to enhance culturally safe assessments. The Australian Psychological Society guidelines encourage clinicians to consider the high burden of trauma, discrimination, the high burden of psychological distress and the need to look for strengths.

Preparation and Context for Assessment

The assessor should be patient and respectful. It is important to introduce themselves and offer some details about who they are. They should take time to get to know the person before deciding on which assessment tools are useful. They should also get to know the community and their cultural context. Consideration should be taken when deciding on the location for the assessment, aiming to conduct it in the natural ecological setting for the person. It may be appropriate to use a cultural broker. Finally, the assessor should be aware of their own beliefs and attitudes and consider how this may impact on the assessment process.

Language and Communication

Language barriers and problems with inter-racial miscommunication may impact on the quality of the assessment. Be aware that English may not be the preferred language for the service user. Good communication skills are critical. It is

important to be sensitive to the language skills of the person and their educational level. Try to adopt a yarning style of interview, rather than the traditional western interrogative approach to medical interviewing. Be sensitive of non-verbal cues such as posture, gesture, eye contact. It is also important to be aware of sensitive topics that may be retraumatizing.

Considerations in Mental State Examination

Caution should be taken when interpreting mental state findings. In particular, practitioners should avoid over-interpretation and culturally-bound inferences. For example, in terms of behavioural presentation, posture, gesture, touch and eye contact, all have cultural interpretations that may differ from one setting to the next. Avoidance of eye gaze, for example, may be a sign of respect rather than avoidance or low mood. Affective responses too, may be a function of cultural clash. Anger and resentment in Aboriginal and Torres Strait Islander people may be more historical than circumstantial. Non-Aboriginal and Torres Strait Islander clinicians conducting assessment are representatives of the dominant culture and may invoke feelings of anger and resentment that are substantially exacerbated by the context, particularly if the review is involuntary. Table 23.1, adapted from Adams et al. (2014), outlines some factors to be aware of in assessing mental state.

Table 23.1. Factors to consider when examining mental state of Aboriginal and Torres Strait Islander Australian peoples.

Appearance	Understand the person's 'usual' standard of self-care and appearance. Identify any changes that may indicate a mental health issue. Consider cultural influences and manifestations such as grief.
Behaviour	Have a good understanding of Aboriginal and Torres Strait Islander culture as it relates to a person's behaviour. Behaviours can be culture-specific.
Affect	Affect can take on cultural forms as not all human emotions are universal. Anxiety and depression for example, may be difficult to diagnose as the manifestation of these conditions could be vastly different across cultures
Mood	An Aboriginal and Torres Strait Islander person's mood may not be expressed in the same way as a non-Aboriginal person. The language used to describe mood may not have meaning for Aboriginal and Torres Strait Islander people and may need to be translated into meaningful terms.
Speech and thought form	Thought disorders may be difficult to detect if the client does not have good English. The clinician would then need to rely on the services of an Aboriginal and Torres Strait Islander health worker or community member.
Thought Content	Aboriginal and Torres Strait Islander spirituality may display as delusional or otherwise cultural. The clinician needs to ascertain whether the primary symptoms pre-date the culturally based retrospective attributions.
Perception	These may be pathologically or culturally based. It is advisable to seek advice from the Aboriginal and Torres Strait Islander mental health worker. Auditory hallucinations are less commonly sited and may be indicative of a mental disorder.
Cognition	Assessing cognition is difficult due to the lack of culturally appropriate assessment tools— assessments of function and activities of daily living are not appropriate in remote communities where living is collective in nature. It is not uncommon for families to seek help as a last resort.

Culture-Bound Syndromes

The DSM-5-TR describes culture-bound syndromes as recurrent, locality-specific patterns of aberrant behaviour and troubling experience that can be

understood within a cultural context (American Psychiatric Association, 2022). Furthermore, they can only be addressed in that cultural context. They may or may not be linked to a particular DSM diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or afflictions, and most have local names. At heart is the need to recognize the different ways of communicating distress. To make sense of these, there is a need to reference culture for understanding experiences.

Tracey Westerman (Westerman, 2021) has validated several culture-bound syndromes in which an understanding of culture is crucial. She highlights the need to understand Aboriginal and Torres Strait Islander grieving practices, and practices of retribution for wrong-doing ('being sung'), which may lead to misinterpretation of presenting phenomena. For example, spiritual visitations may be misinterpreted as hallucinations, or sorry cuts may be interpreted as self-harming related to depression or complex trauma rather than a response to a bereavement. Symptoms such as a weakened spirit and community disconnection (longing for country) may require cultural resolution and healing with culturally appropriate counselling services.

Assessment Models and Tools

As discussed above, the commonly used Western tools DSM and ICD have made cultural adaptations to assist in assessment and diagnosis. In addition, there are numerous validated culturally sensitive tools now available when working with Aboriginal and Torres Strait Islander people. One such example is the *Mental Health Stay Strong Care Plan* (Menzies School of Health Research, 2008). The comprehensive package of support materials provides a series of culturally appropriate stages of assessment and care planning options for supporting mental health in Aboriginal and Torres Strait Islander communities. The package incorporates an understanding of the holistic nature of Aboriginal and Torres Strait Islander health and mental health. Their 'grow strong mental health tree' combines the visual with the written word to explain mental health issues and provide a framework for exploring them in a cultural context. In this area, more work needs to be done to develop a comprehensive suite of culturally validated tools. Table 23.2, adapted from Adams et al. (2014), lists other culturally validated instruments.

Table 23.2. A List of Culturally Validated Assessment Tools.

Assessment Tool	Description
The Westerman Aboriginal Symptom Checklist Youth (WASC-Y), The Westerman Aboriginal Symptom Checklist-Adult (WASC-A)	Youth 13-17 years, Adults aged 18 years and over. Identifies risk of anxiety, depression and suicidal behaviour whilst factoring in cultural resilience.
Kimberley Indigenous Cognitive Assessment tool (KICA)	Cognitive screening tool that assesses dementia in older Aboriginal and Torres Strait Islander Australians living in rural and remote areas.
Strong Souls	Assesses social and emotional wellbeing of Aboriginal and Torres Strait Islander youth. Measure for depression, anxiety, suicide risk, and resilience.
Negative Life Event Scale	Assessment of psychological wellbeing in Aboriginal and Torres Strait Islander Australians. Measures exposure to stress.
Kearins' Visual Spatial Memory test	Assessment based around research with Aboriginal and Torres Strait Islander children aged 6-17 years that focused on task behaviour.
Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ)	Culturally competent measure of specific traumatic stressors and trauma symptoms criteria for PTSD. This questionnaire includes specific cultural idioms of distress reactions that are relevant to Aboriginal and Torres Strait Islander people.
The K-5 measure of psychological distress	A subset of five questions adapted from the Kessler Psychological Distress Scale-10 (K-10) developed in 1992 by Kessler and Mroczek (ABS 2003).
The K-10	A non-specific psychological distress scale of 10 questions to measure levels of negative emotional states experienced in the 4 weeks prior to interview.
Kimberley Mum's Mood Scale	Currently in development as an adapted version of the Edinburgh Postnatal Depression Scale and is currently being validated across the Kimberley in Western Australia. This tool screens for depression and anxiety.
Q Test	Cultural-fair, language-free assessment measure of cognitive functioning screening and trainability.

In summary, in participating in the acts of mental health assessment and diagnosis, the practitioner needs to be aware of the need to decolonize these processes. We should aim to shift the discourse from one of distress to a discourse of hope. This can be facilitated by the adhering to the key principles of

acknowledging white privilege and understanding Aboriginal and Torres Strait Islander terms of reference.

Considerations in Management

In theory, all the treatment modalities and technologies described in this book can and should be considered when treating Aboriginal and Torres Strait Islander people. In this section we describe some overarching principles to take into consideration when working with Aboriginal and Torres Strait Islander service users.

To work effectively with Aboriginal and Torres Strait Islander people, practitioners must recognize that the Western biomedical model is often inadequate, and if used in isolation is potentially harmful. The vision articulated in the NSW Aboriginal Mental Health and Well-being Strategy 2020-2025 (New South Wales Ministry of Health, 2020) articulates the key cornerstones of care: that Aboriginal and Torres Strait Islander people will have access to holistic and person centred/family centred care. Care should be delivered in a culturally safe and trauma-informed manner. And finally, there should be a focus on healing practices.

Practitioners must always keep in mind the risk of engaging in paternalistic and coercive practices that mimic the process of colonisation. It is important to be aware that Aboriginal and Torres Strait Islander people may be mistrusting and suspicious of mainstream services. They may be wary of presenting to services voluntarily and may do so only when their symptoms are advanced. Practitioners must be aware of the need to promote a sense of trust and safety. In this regard, the same principles discussed in the previous section about assessment and diagnosis also pertain to management. In addition to the principles listed in the section above, some further considerations include:

1. The location for care - Hospitals and emergency departments can be noisy and frightening places. If possible, try to conduct assessments or therapy in quiet locations with access to the outdoors, or in designated culturally safe spaces.
2. Informed consent - When a treatment plan is explained, care must be taken to consider the educational level and proficiency in the language being used. A cultural broker can help in these circumstances or a family member.
3. Keep family and community informed of any assessment outcomes and treatment decisions as soon as possible, if they are not present.
4. Respect the need for privacy and confidentiality at all times.
5. Avoid the use of coercive treatment wherever possible, including involuntary treatment orders and restrictive practices under mental health legislation or other legislation. If this is necessary, keep involuntary

treatment as brief as possible. This pertains in particular to the use of seclusion and restraint, as well as involuntary hospitalisation.

6. Be aware of social hierarchies that may exist within communities and the need to respect elder status and community leader status. The practitioner's gender and age may impede the development of a strong working relationship.

The practitioner should keep in mind the importance of connection to country and kinship ties. If there is an opportunity for a person to undergo healing on country and in their own community, this should be facilitated. If possible, try to create opportunities for the person to reconnect to their country and the cultural and spiritual practices of their elders. Connection to community is an important part of healing.

Enhancing or restoring cultural identity is a healing practice. Formulating a 'cultural wellness plan' can be helpful. This process identifies key cultural signifiers for the person, including the person's country or nation of origin, relevant language group, significant family or community members, identifying their totem, relevant community dreaming stories and other relevant cultural and spiritual practices.

Self-determination is also an important factor in promoting good health. At the level of the individual, this means allowing the person to work alongside practitioners to make informed choices about their own treatment. Management plans should be co-designed, ideally with the support of family and community members. This will help to identify which are the important healing practices for that particular person.

Practitioners should be aware that navigating health services may be difficult for Aboriginal and Torres Strait Islander people. Help may be needed in identifying local health resources, both general and Aboriginal and Torres Strait Islander Australian-specific. Again, the Aboriginal Mental Health workforce is helpful in navigating health systems.

There are some particular considerations in regard to biomedical aspects of care. Some of the pharmacological agents used in psychiatric practice can have a strong impact on weight, cardiac and metabolic function, including in particular the second-generation antipsychotics, clozapine and mood stabilizers. Given the relatively high incidence of obesity, type 2 diabetes, heart disease and hypertension, caution should be taken to use the lowest possible doses, or to choose a cardiometabolic-sparing agent where possible. Similarly, caution is recommended when using lithium and other agents that are entirely renally excreted, given high community rates of renal disease.

Compliance with prescribed medication poses challenges in circumstances where coercive treatment practices may retraumatize, especially in involuntary administration of depot medication. Where possible, enlist the assistance of family or community members to increase the likelihood of oral medication compliance, in preference to depot medication.

Finally, practitioners should be aware of the presence of traditional healing practices and the possibility that these can co-exist with Western medical practices, or even replace the need for them. There are multiple examples of innovative traditional healing practices, resources, and registered Ngangkari traditional healers.

Broader Considerations

Thinking more broadly, health service providers can assist in ensuring that their services are ready to provide care that is culturally safe, and trauma informed. This means ensuring that all practitioners are trained in cultural competence and that the physical environment is a welcoming space with readily recognizable symbols of Aboriginal and Torres Strait Islander cultural and language.

There are considerations at a national level. In keeping with the principle of empowerment and self-determination, Aboriginal and Torres Strait Islander people should be given the chance to design and operate health services that are tailored to their particular needs. This has been the vision of Aboriginal Medical Services which have been operating across the country since 1970s.

Furthermore, the burden of mental health problems in the Aboriginal and Torres Strait Islander community cannot be comprehensively addressed until the existing social inequities are corrected. The Closing the Gap scheme aims to rectify the social disadvantage Aboriginal and Torres Strait Islander Australian experience on key social determinants of health yet has failed deliver on almost all measures so far, especially in relation to Aboriginal and Torres Strait Islander suicides.

Finally, healing cannot take place without truth telling and reconciliation. Aboriginal and Torres Strait Islander people need to have their perspectives on historical events heard and recognized as valid. Judy Atkinson (Atkinson, 2017) talks of the value of deep listening. Until we start listening and learning about the depth and complexity of historical and contemporary factors affecting the health and wellbeing outcomes for Aboriginal and Torres Strait Islander Australians, we cannot hope to support individuals and communities in the work that is currently being undertaken to resolve some of these outcomes. By valuing the experiences, and

better understanding the circumstances of many Indigenous populations, we can improve our own capacity to support those who are most vulnerable and in need.

Now brood no more
On the years behind you,
The hope assigned you
Shall the past replace,
When a juster justice
Grown wise and stronger
Points the bone no longer
At a darker race.

From Song of Hope (Oodergoo of the tribe Noonuccal, formally Kath Walker).

Further Reading

Australian Indigenous Health infonet: **healthinfonet.ecu.edu.au**
The Mayi Kuwayu Study: **mkstudy.com.au**

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