

A model of therapeutic intervention with Indigenous Australians

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There is little information available to mental health practitioners pertaining to culturally appropriate and sensitive methodologies for use in the assessment and therapy of Aboriginal clients. The research that is available is mostly epidemiological in nature rather than practice oriented. In the light of this lack of practical information, a psychological intervention model developed for working with Aboriginal clientele is outlined. This model is further delineated in a case study.

A model of intervention

The proposed model focuses on building a relationship with the Aboriginal community, family or client. Once this rapport has been established, psychological practice can be introduced. The introduction of therapeutic models and options is an open and transparent process aimed at demystifying Western interventions and empowering the client. The model has been successfully applied to individual, family and community settings.¹

When a non-Aboriginal mental health practitioner receives a *referral* (stage 1), the nature of the referral should be carefully examined. In some cases it may not be appropriate for the mental health practitioner to accept the referral (e.g., in the case of a male mental health practitioner being referred a case that relates to Aboriginal women's business or vice versa). All referrals should be discussed with cultural consultants to assess the appropriateness of the suggested contact. In some cases the

consultant may suggest another more culturally appropriate avenue for treatment. They may also suggest that the intervention be conducted with the cultural consultant taking the lead role.

Once the referral has been discussed and accepted, the next step for the non-Aboriginal mental health practitioner is to thoroughly *examine* (stage 2) the client's background and history. This will require the written permission of the client so that information can be released without breaching confidentiality. An understanding of local Aboriginal history (e.g. effects of colonisation, the stolen generation, health and welfare issues, land claims), and the client's family history (recent deaths, feuds, etc), may assist in providing a holistic representation of the case. Consults with Aboriginal co-workers are essential in identifying important pieces of information that may otherwise have been neglected. A check through existing notes and files may also add important information, although in most cases it will be the cultural consultant who provides the most recent and valid information.

When the research has been completed, *potential limiting factors* (stage 3) of the intervention are identified. Some of these factors may have become self evident during the research phase of the intervention and require certain plans and strategies to be developed to maximise the efficacy of the proposed intervention. These may include the proposed location of therapeutic contact, who should first engage with the client and

Abstract

Many non-Aboriginal mental health practitioners are confronted by the lack of practical information pertaining to interventions with Aboriginal clientele. Subsequently, this may have engendered uncertainty in potential therapists and counsellors due to the lack of reliable, practical and culturally appropriate information. Those non-Aboriginal mental health practitioners working in the field with Aboriginal clients do so with varying degrees of success and build upon their knowledge base through personal experience and anecdotal information. Unfortunately, this information is often not made available to others working in the field through journal publication. This Practice Note examines a model of intervention aimed at developing relationships to enhance therapeutic interventions at the individual, family and systems level. As a way of clarification, the model is described via a case study involving a psychological intervention with a remote Aboriginal community.

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how, the time and length of the session, gender, and what subjects should be avoided in contact with the client (e.g. traditional law).

Engagement (stage 4) with the community or family can be carried out in a number of ways. If the Aboriginal co-worker has an existing relationship with the community or family, they can introduce the non-Aboriginal counsellor to the relevant people (i.e. elders, parents and grandmothers). If an existing relationship has been established, the process described below should be carried out when meeting face-to-face with the significant people. Conversely, if no relationship exists the co-worker may choose to telephone or write to the community/family concerned and provide information about the proposed visit. It is important that the community/family are clear about the reasons for the visit, who will be visiting and what topics are likely to be discussed. In other words, the purpose for the visit should be transparent, which allows the clients to select other community/family members they would like present at the meeting.

This process is extremely important because it allows clients to ask questions and offer opinions about the format of the proposed meeting and intervention (such as the significant people they would like present at the meeting and why). It is important that the rationale for the visit and topics to be discussed are identified at the first contact. No intervention should be conducted at this time. The family should be provided with their options as to the intervention of their choice; they should be encouraged to identify any culturally appropriate means of dealing with the problem at hand, which should also be incorporated into the intervention. Choice of culturally appropriate interventions may require the counsellors to co-work with traditional healers.

The role of the non-Aboriginal mental health worker should also be clearly delineated with the client at this time. If the client agrees to the co-workers' arrangement, it is important that the non-Aboriginal counsellors make themselves available to visit at the same time as their consultant and that she/he be involved until such time as the intervention ceases. It is not advisable to miss meetings or change meeting times. Consistency in approach is the key, which allows the community/family to develop a relationship with the worker and facilitates the development of trust. The development of the relationship is a key factor in the success of the intervention. The non-Aboriginal mental health worker should also discuss their limitations in terms of knowledge of Aboriginal culture.

Frequency of contact (stage 5) should be discussed with the client. The client should be informed that contact times are negotiable and are their prerogative. Sometimes, depending on the type of intervention, regular contact times are required. This should be explained to the clients and they should be encouraged to select the times that suit them but in a more regular time frame. Clients should be encouraged to make other times if they find their scheduled meeting time is not suitable. This requires counsellors to be flexible, especially when co-working with a traditional healer. It is important to note that once the ground rules have been established in the first (and perhaps second) meeting, a time should be made for the assessment and intervention to commence.

The client should also be informed about their *therapeutic options* (stage 6). This may present a unique opportunity for Indigenous and Western methods to be used together and to learn more about each other's skills and strengths. When discussing therapeutic options, the counsellors should also discuss a variety of Western models and their strengths and weaknesses. The client is encouraged to select the intervention option they feel most comfortable with. As has been stated earlier, maintaining an open therapeutic process is likely to reduce any anxiety the clients may have, and it also helps to demystify interventions. This also empowers the client to choose the intervention of best fit. The intervention should continue to be an open process that allows feedback from the client involved, the workers and other cultural consultants.

Once the intervention has been completed, *follow-up (evaluation)* (stage 7) should be discussed. This can either be formal or informal and is dependent upon the client's choice. For example, the client may choose a formal meeting time or may decide to discuss the matter informally when next they see the workers. At this meeting it is important for the mental health workers to provide feedback to the client on the intervention's progress and possible options available for them should they require future assistance. Another important element of the follow-up process is for the counsellors to evaluate the service they provided to the client. The intervention process is evolutionary and therefore dependent upon feedback and evaluation to improve service delivery.

Once *closure* (stage 8) has been achieved, the counsellor needs to be aware that their ex-clients may continue to discuss family/community matters when they see the workers. They may also act as referral conduits to the workers if news of a positive experience with the counsellor spreads. If the intervention process has been perceived as beneficial, ex-clients often become a source of favourable comments and feedback and this in turn can lead to more Aboriginal clients accessing the service.

The model described in this paper has been developed on the basis of experience working with individual clients, however the principles apply equally well at the family or community levels. The following section illustrates an applied example of the model in a large-scale community intervention.

The model in practice: a case study

A small Aboriginal community in the north of Western Australia was experiencing numerous negative consequences as a result of non-organic failure to thrive (FTT). A number of the mothers in the community were very young and had few opportunities to learn parenting or nutritional skills from either their own mothers or extended family. A local group consisting of 'grandmothers' and elderly aunts requested that an FTT parent-training course be run in the community so the young mothers could learn these skills. This request was passed to the author, a male, who then followed the intervention model previously described.

The first step was to examine the referral/request (stage 1) and assess the appropriateness of undertaking the work. The assessment of the request was conducted in collaboration with Aboriginal colleagues who felt that, given the community had requested that the

course be undertaken and that they were also aware of the model used by the author(s), they determined that the request was appropriate. As part of stage 2, the community was extensively researched via the literature and through discussions with an extensive network of local cultural consultants. This involved numerous visits to the community. All of the visits were undertaken in conjunction with a female cultural consultant as it was identified, in stage 3, that a single non-Aboriginal male therapist would be unlikely to gather the depth of information required to undertake the project. The visits highlighted other potential limiting factors such as distance, time and lack of knowledge on behalf of the non-Aboriginal worker. The author, cultural consultant and the female community elders developed strategies to prevent the identified problems from occurring. The author and the consultant met with the grandmothers and aunts to develop a relationship and to gain greater understanding of their needs. The group was then asked if they were happy with the mental health worker and cultural consultant's involvement in the project. The women agreed to input from the health worker and cultural consultant but would act as an executive steering committee, with the right of veto (stage 4). The steering committee was also very much involved in the development of the framework, content and cultural aspects of the FTT training package. The women agreed to meet on a weekly basis at approximately the same time (stage 5). The group met at a small local government facility regularly used for community meetings. The women encouraged the counsellors to ask questions to avoid potential mistakes. When mistakes were made these were highlighted and discussed with the workers.

The regular meeting facilitated the program development that the elders felt would best suit the community's needs based on their knowledge and experience in dealing with the young mothers living in the town (stage 6). The result was a six-session training package that covered:

- parenting skills, both Indigenous and Western approaches;
- traditional nutritional practices;
- identification of locally accessible wild foodstuffs;
- identification of the requirement to maintain strong culture through raising strong children;
- signs of non-organic failure to thrive; and
- strategies and supports to overcome FTT on the individual and community levels.

The elders asked that the female cultural consultant, with their input, deliver the first training package. The committee felt that having a male present the information to the target group was inappropriate. However, the female presenter could incorporate the information provided by the male author.

Upon the completion of the training program a meeting was scheduled between the steering group and the authors to allow for reciprocal feedback and qualitative information to be gathered (stage 7). The grandmothers and aunts were very pleased that the process encouraged them to develop a package that suited their unique needs and then to deliver it to their community.

The first training sessions were highly successful, with qualitative evaluations overwhelmingly supportive of the blend of approaches. On numerous occasions, the grandmothers and aunts

reported that the FTT parenting program had significantly increased the parenting skills and knowledge of the young mothers of the community. The older women reported that they were caring for the young children less frequently due to the 'young mums' caring for their children more appropriately. The committee indicated that it was extremely pleased at being able to incorporate the community's expectations of motherhood (e.g. Indigenous child rearing/nutritional practices) combined with Western information (e.g. nutrition, child development, long-term effects of FTT). In a follow-up six months after the FTT parenting program, the community reported that the gains made had been maintained and they were making plans to run another course. At follow-up the steering committee did not envisage a further role for the authors, although they were very enthusiastic in maintaining contact principally to ensure that the consultative link was not diminished (stage 8).

The maintenance of behaviour change by the target group may have been unique to this Aboriginal community. There was a great deal of community expectation that the program would succeed because the content was developed by community elders and facilitated by respected Aboriginal community members. All of the group members were highly motivated and attended group with the support of the community. The 'young mums' also had access to a group of older women who were familiar with the program and could provide individual advice and instruction as needed. When problems did occur, the community worked together to support the young mother and family, which was generally successful in preventing a child being hospitalised due to FTT.

Conclusion

There is limited information pertaining to how the non-Aboriginal mental health practitioner might optimally work with Aboriginal clients. An ideal process represents an amalgam of suggestions made throughout the literature, ongoing discussions with numerous Aboriginal clients and elders and discussions with Aboriginal colleagues. The proposed model is evolutionary and certainly not a panacea to be applied with every Aboriginal client or community, but represents a useful initial process. The importance of further research, evaluation of models of practice, networking, developing relationships with cultural consultants and investigation into Aboriginal mental health beliefs will provide guidance to health workers in the future as well as enhancing the process of therapeutic engagement and intervention.

It is crucial for non-Aboriginal mental health counsellors intending to working with Aboriginal clients to be both flexible and lateral in their approach. They should be prepared to stringently evaluate the efficacy of Western intervention methodology when employed with Aboriginal clientele and have an open mind to suggestions made by their cultural consultants and clients.

References

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