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Intervention model with Indigenous Australians for non-Indigenous counsellors

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Abstract
A number of papers have introduced some intervention models and strategies for working with Indigenous people for non-Indigenous practitioners. The lack of engagement of Indigenous people in mental health services, however, is still the main difficulty faced by the practitioners, including both Indigenous and non-Indigenous counsellors. It is speculated that there is more than cultural factors involved in getting Aboriginal clients to engage in mental health services. This paper proposes an intervention model that considers cultural competence, trust and practical assistance in working with Indigenous Australian clients.

Introduction
Over the past few decades, too few papers have been published on the subject of an intervention model involving Aboriginal people. It was only during the 1990s that papers began to be published on an important perspective on the therapeutic approach to work with Indigenous Australians. The prominent example of this has been the work of Judy Atkinson (1997, 2002).

Since then the number of studies on Aboriginal clients has increased and their common feature has been to illustrate the traumatic impact that colonisation has had on them. Many non-Aboriginal mental health practitioners are still confronted by the lack of practical information on therapeutic interventions with Aboriginal people (Vicary & Andrews 2001; Waterman 2004). A number of papers have introduced some intervention models and strategies for non-Indigenous practitioners to work with Indigenous people (Vicary & Andrews 2001; Waterman 2004; Armstrong 2002; McLennan & Khavarpour

2004; Blagg 2000). Their models of intervention have developed significant insights into how counselling professionals should work with Indigenous people. However, the major difficulty that practitioners face is the lack of engagement of Indigenous people in mental health services (Westerman 2004). Most authors have attributed the lack of engagement of Aboriginal clients in mental health service to the cultural differences and experiences of the non-Indigenous practitioners (Westerman 2004; Vicary & Andrews 2001; McLennan & Khavarpour 2004). However, it has been proposed that Aboriginal workers have also expressed much difficulty in getting their Aboriginal clients to participate in the service. Therefore, it is speculated that there more than cultural factors are needed in getting Aboriginal clients to use the mental health service. Therefore the challenge presented by this situation is to develop an intervention model that is suitable for Aboriginal clientele and is practical in improving their sense of engagement with the mental health service.

Barriers to engagement of Aboriginal people

Most research indicates that cultural barriers are the major reason why Aboriginal people are discouraged or dissuaded from using the mental health service. Writers who have come to this conclusion have speculated that the mental health service has failed to identify, acknowledge and recognise the central role of Indigenous culture (Vicary & Andrews 2001; Westerman 2004). For example, it is not suitable to refer to a dead person by name and Aboriginal people view hallucination or delusion as spiritual experience (Armstrong 2002), not necessarily as symptoms of mental illness. These instances illustrate some of the great differences between Aboriginal and Western cultures. Positive results in getting Aboriginal clients to use the mental health services will be achieved by developing programs of cultural competence. The use of cultural consultants can help to increase cultural competence.

Historically, there has been a long period of mistrust among the Aboriginal people and white Australians. Federal governments for much of the twentieth century developed paternalistic policies and practices that regarded the removal of children from Aboriginal families as essential for their welfare. Continuing statutory responsibilities for the protection of children have made many Aboriginal women fear approaching the Department of Family and Community Services for assistance, especially in domestic violence and child abuse issues. It is a fact that Aboriginal people have and continue to experience being discriminated against by white Australians. A large socio-economic gap exists between white Australians and Aboriginal people (Chambers 1990). It is not uncommon for some workers to hesitate in introducing their service to the Aboriginal people as being funded by or connected in some way to the Department of Family and Community Services. They fear that their background may drive away Aboriginal people from using their service. Therefore, the barrier includes not only the mistrust among the Aboriginal people on white Australians but also the distrust of white Australians being trusted by the Aboriginal people. It is precisely this sort of alienation or distrust between the Aboriginal people and the service providers that is creating problems, namely discouraging Aboriginal people from using the mental health service. Working with Aboriginal workers can be a useful bridge to link with the Aboriginal community. Aboriginal Liaison Officers, if utilized properly, have the potential to help build alliances

or significant relationships between non-Indigenous counsellors and Indigenous clients (Vicary 2002; Westerman 2004). Despite there having been recorded experiences of both Aboriginal counsellors and non-Aboriginal counsellors attempting to keep Aboriginal client engaged in the mental health service, it is evident that some Aboriginal clients may only turn up for one or two sessions but drop out of the system. The possible factors behind their lack of motivation to keep engaging in counselling service lie in the means of assistance they are looking for.

The problems of engaging Aboriginal clients in service exist mainly because mainstream services have not provided relevant responses to their crisis situation. Aboriginal clients would first seek practical assistance such as refugee accommodation and food, and they would also seek assistance from their families, extended families or their own communities. Despite the ravages of over two centuries of displacement caused by colonisation, Aboriginal people have retained strong kinship ties and extended family commitments. As in traditional times, Aboriginal people feel a great obligation to their kinship ties. The extended family will always be first in helping if there is a crisis or even a slight problem. For example, an Aboriginal woman may seek assistance with food vouchers because she currently needs to look after a large number of her extended family as well as her own immediate family (WACOSS, 2004). Only when they cannot get enough or suitable help from their extended family or their own community, will they turn to outside welfare or service provided by the Department of Family and Community Services (Chambers 1990).

This helps to explain why Aboriginal people find it difficult to engage in mental health or counselling services. Their first priority is to stay alive and such services only become important when Aboriginal or non-Aboriginal healthcare workers need can provide practical assistance to Aboriginal clients. Once the Aboriginal clients find the services do not provide what they needed, it is very difficult for Aboriginal workers to keep Aboriginal clients engaged in their service. Aboriginal clients may resort to turning to other agencies for assistance. The barriers to engagement of Aboriginal people in the mental health service are illustrated in Diagram 1 overleaf. Having clarified the reasons why problems exist in getting Aboriginal people to make any use of the mental health service, then is it possible to propose a plan that bridges the gap between representatives of the service and Aboriginal people.

Diagram 1: Barriers of engagement of Aboriginal people in mental health services

A model of intervention

The proposed model focuses on the bridge between the service and Aboriginal people, as shown in Diagram 2. Once the needs of the Aboriginal people have been met, it can build a relationship with the Aboriginal people and improve their participation in and acceptance of the mental health service. Furthermore, this model applies both to Aboriginal and non-Aboriginal workers who are required to intervene with Aboriginal people. This model consists of three key aspects that need to be considered before workers can intervene in Indigenous people's core psychological problems and mental health issues. They are: cultural competence, trust and practical assistance and these three components are the key factors to removing the barriers surrounding Aboriginal communities and resolving serious crisis issues.

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Diagram 2: Model of Intervention

Cultural Competence

It is also important to provide cultural awareness training for staff by being familiar with local environment, and knowing the different cultural and linguistic groups living in the local area, in order to assist staff in understanding the cultural practices of these groups. Gender rules within Aboriginal cultures are important and must be respected whenever possible regarding intervention. Ideally, women staff should work with women and male staff should work with men. Women may feel embarrassed talking to male staff and men may feel shame if helped by female staff.

Trust

In building a trust with Aboriginal people, most Aboriginal people would prefer to work with an Aboriginal worker regarding their problems. However situations may arise where clients may know or be related to an Aboriginal worker. They may feel shame or be restricted through kinship rules in discussing personal problems with them. Fear that the worker will breach confidentiality with the local community may be another concern. Where possible, clients should be given the choice of both Aboriginal and non-Aboriginal workers.

Nevertheless, it is important for workers and counsellors to work together with an Aboriginal worker in their community. Counsellors or practitioners can work with the C.D.E.P. or the Aboriginal Liaison Officer (ALO) employed by either the police or Community Health Service. The ALO is usually a principle stakeholder in the Aboriginal community and receives first-hand information about the Aboriginal community. The ALO is often the first point of call for Aboriginal clients in that the ALO can refer and introduce clients to the agency. The ALO can assist the client "feel at ease" at the agency. A number of published papers have highlighted the need for the major services to operate an outreach capacity (Dudgeon et al. 1993; Westerman 2002). Aboriginal people are more likely to engage with practitioners who are highly visible in their communities (Vicary 2002). Moreover, working with ALOs who undertake home visits can help workers develop strong and sustained networks with the Aboriginal community. Once Aboriginal people know the workers and how they go about their business, they will know who they can ask for help. They will take the initiative in approaching the service for helping concerning their children and family problems.

Practical assistance

Aboriginal clients usually take the initiative in seeking assistance when a crisis emerges, such as domestic violence or electricity services being disconnected, or having no money to buy food and other essentials for their children. As stated previously, Aboriginal people would first consider practical forms of assistance, such as legal advocacy, crisis care, transport arrangements, financial assistance, medical services, accommodation, food vouchers, and even making a few calls at their office when a domestic problem arises. This sort of assistance is what they really want, not just "talk therapy". Before they can sort out their basic living problems, they may not have the capacity or attention to deal with other psychological issues.

Exploration and Treatment

Once Aboriginal clients have settled down and taken a calmer approach to their predicament, it still does not guarantee they will stay with the service. It is not uncommon that once they have solved a problem, they will feel it not necessary to remain a part of the service but may come back a few months later for help when another issue arises. If mental health service workers, for example, have patiently developed a good relationship or rapport with them, workers can take advantage of this by reminding their clients of the good they can do when relationships or domestic situations are at risk. The ability of workers to invite clients to talk about their problems may make it possible to explore other problems. Aboriginal clients' particular issues or crises may be linked to other problems, such as child abuse, alcoholism, mental health, unemployment and parenting problems.

Interagency Cooperation

At the point of crisis, workers must be aware of the special needs of clients. Clients' problems may be beyond the capacity of the sole service or worker to manage, let alone resolve. Workers are advised to develop a good network and cooperate with other services, such as family and children's services, community health services, mental health services, legal aid consultancies, women's shelters and refuges, police officers, doctors and representatives of the church. Clients may need to be referred to other support services in order to handle their complex problems. This may help to think about the deep-rooted problems and ensure that healing and preventive work has long-term benefits, rather than just obtaining help that works in the short-term.

Conclusion

It is crucial for the workers to build a trusting relationship with the Aboriginal community. Cultural competence and working with Aboriginal Liaison Officers is an important step towards building a mutually trusting relationship. A relationship that is simply based on "talk therapy" will not work for Aboriginal clients. Furthermore, workers need to know where to get practical assistance for Aboriginal clients. Otherwise, Aboriginal clients may only turn to those services that can really assist them. Services of this kind become a meaningful referral point within their community.

Before our service has tried the new model of intervention, the Aboriginal people made up less than 8 percent of the total clientele each year in the past few years. Since 2005, the percentage of Aboriginal clients has soared to 58 percent of the total caseload. The proportion of Aboriginal people seeking counselling services has risen alarmingly compared to the past few years. There may be other reasons contributing to the success or otherwise of engaging Indigenous clients, including having a Chinese culture counsellor working in the service which has an ethical match effect in attracting Aboriginal clients. It is therefore necessary to have more research-oriented studies that explore the influence of cultural background on the facilitation of working with Aboriginal communities.

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