Leave only footprints: cultural sustainability and mental health in a remote Aboriginal setting

Sheldon Remote Mental Health Team, Central Australia

Introduction

The notion or phrase “Leave No Footprints” was adopted by the Sheldon Remote Mental Health Team in Central Australia in 2000 as an expression of its philosophy of working in remote Aboriginal communities. It was developed over the years 1998 to 2000 as a working (and evolving) document “to capture the essence of providing efficient and effective services and supports without unnecessarily disturbing or damaging the natural order of things, the ‘what works for individuals, communities and cultures.’” (Thomas 2000 unpub). It represented a “blueprint for mental health service delivery throughout remote central Australia”. The notion “leave only footprints” or “leave no footprints” was derived from the burgeoning literature of ecology, and low impact eco-tourism, and propounds the ethic of environmental sustainability. In the context of mental health the notion attempts to express a commitment to the sustainability of Aboriginal culture. It represents a statement of the philosophy and practice of the Sheldon Remote Mental Health Team, not a Strategic Plan nor an analysis of the status of Aboriginal mental health.

The theoretical basis underlying “Leave Only Footprints” is that of the ‘Recovery Model’ developed by the Canadian Mental Health Association (Trainor, Pape et al. 1993). In this model it is emphasised that sufferers of so-called “mental illness” recover not just because of psychiatric treatment from a specific organisation or service, but draw upon a plethora of resources and community supports to aid their well-being. This may include the local library or Church as much as the Mental Health Services.

In the literature on Aboriginal Mental Health we can link this model with that of the concept of “Social and Emotional Well-Being”. This concept attempts to define “mental illness” more holistically, and emphasise a more culturally appropriate approach to such problems, rather than a narrow disease or illness paradigm of western medicine. Social and emotional well-being acknowledges the connection between family, culture, land, law and spirituality.

With these two theoretical underpinnings, various practice principles and issues then become apparent, which shall be outlined. These include: the ‘Aboriginal’ construction of self; the importance of cultural stress and transference; culturally appropriate practice; the use of cultural consultants; the role of traditional healing practices; incorporating a Narrative Therapy approach to ‘counselling’; the importance of psychoeducation; and finally there is a personal challenge to embrace ecopsychology as a more integrated psychiatric paradigm.
Recovery and history

There is a clearly established connection between the incidence and recovery from mental illness and the state of the political economy, at any particular historical juncture (Warner 1994). Risk factors for mental disorders have been identified as such factors as: "poverty, social disadvantage, violence, family discord, abuse, substance abuse, life stress, separation in childhood and so forth." (Swan Pt 2 1995, p37) The New Framework For Support (Trainor, Pape et al. 1993) emerges from this perspective. While it "recognises the importance of mental health services the Community Resource Base also includes the role of family and friends, generic services and supports, and consumers working together on their own behalf. It also acknowledges some fundamental elements to which every citizen should have access: housing, education, income and work." (1993) This approach could not be more apt when coming to grips with the phenomena of mental illness in the context of Indigenous communities.

We would only add general health as a fifth element to this resource base, which is critical in its connection with mental health issues.

Aboriginal people emphasise the strong relationship of mental health and well-being to physical health and saw loss of mental well-being as contributing in a major way to the poor physical health and health outcomes of Aboriginal people. (Swan Pt2 1995 p1)

Indeed the co-morbidity of physical and mental health is seen as a major area for further consideration (Swan Pt 2 1995 p23–24).

Social and emotional well-being

The Ways Forward Consultative Report (Swan 1995) was the culmination of much thinking and reflection from the Aboriginal community about the nature of mental health. The literature that includes: All that rama rama mob (Dunlop 1987), the First National Indigenous Mental Health Conference (1989), Joseph Reser's classic article "Aboriginal mental health: conflicting cultural perspectives" (Reser 1991), and the Burdekin Report (Burdekin 1993) all tend to culminate in the notion of "Social and Emotional Well-Being".

The “Aboriginal concepts of mental health are holistic” (Swan Pt1 1995 p1). Fundamentally this means an “acknowledgment and a respect for, the interconnectedness of kinship, culture, law, land and spirituality when working in Aboriginal Mental Health” (Thomas 2000 p3). In practice this implies that Mental Health Services works in partnership with various other agencies and the community in meeting identified needs. This has significant implications for service provision, which may mean going beyond narrow ‘core’ business. For example domestic violence or petrol sniffing may be the primary identified needs of a community, so Mental Health has to be prepared to work out of the square, appreciating that the core business of psychosis or depression almost certainly is connected to these issues, when approached from the holistic perspective of Social and emotional Well-Being. By adopting the concept of social and emotional well-being it becomes incumbent on Mental Health Services to have a broader, more flexible, definition of the nature of mental health; adopt more culturally appropriate practices; and embrace the central role of traditional healing practices.
Aboriginal construction of self

We know that historically there have been hundreds of distinctive Aboriginal languages spoken in Australia, and as many distinctive cultures, and ways of being. In Central Australia alone we can identify at least half a dozen language and tribal groups. This includes the Walpiri in the north-west; Pintubi-Luritja in the west; Anmatyerre and Alywarre in the north; Arrernte in the central region; and the Ngaanyatjara-Pitjantjatjara-Yankunytjatjara in the south. All of these tribal and language groups meet, interact, intermarry, and relate to each other in the melting pot that is Alice Springs. However, for the mental health practitioner, despite this anthropological complexity, there are some basic common elements that arise about the Aboriginal construction of ‘self’ that have implications for practice.

Firstly, and most obviously, is the sense of collectivity (Andary, Stolk et al. 2003), of family or kinship relationships. “Self” in an Aboriginal context “is seen to incorporate one’s family and extended clan group, with a complex of relational bonds and reciprocal obligations” (Swan Pt2 1995 p 35). This has many implications for assessment of the nature of social stressors, obligations, and responsibilities for treatment. But at deeper level we have to appreciate that when the sense of self dissolves into the Other of kinship relations that the disease process, and its recovery, may be beyond the individual. The loss or fragmentation of self “can lead to mental ill health” (Swan Pt2 1995 p35).

Second is the profound sense of continuity with self and the greater Aboriginal Law and Dreaming. This can be seen both in the positive sense as a source of strength and identity, but also in the sense that that Law may have been betrayed, broken or lost. This can therefore affect social being and even health.

Thirdly social interaction and communication can be more circumscribed. Body language and context therefore can be more important, who one talks to, gender issues, how one sits, asks questions, gets answers, all require special cultural sensitivity. Self, if you like, lies in social being, which is manifest in communication style and patterns.

Internal and external locus of control

Even more slippery than the concept of ‘self’, is the idea that there may, indeed, be an Aboriginal ‘psychology’ of sorts. This can be fraught with cultural stereotypes and racial stigma, especially in early studies of intelligence (Kearney, De Lacey et al. 1973).

However the concept of internal and external locus of control may be an useful way to explore the possibility of an ‘Aboriginal’ psychology, and may be consistent the notion of collectivism. The concept is used to explain how certain personality differences may make some people more vulnerable to stressful events (Burns 1992 p52). People who “see themselves as having control over their environment are less likely to be affected by stress” (Burns 1992). “Locus of control” therefore “refers to the degree of control that individuals think they have over what happens to them.” In the negative sense ‘externals’ will tend to feel the victim of circumstance, blame others, or need the recognition and reinforcement of others or even outside events. In a more positive sense the external has a more ecological perspective, recognising the complex interrelationship with others and the environment. ‘Internals’ on the other hand may be more inward, self-blaming, and insular or thick-skinned—but less prone to be susceptible to stressful events. They may be more independent, but more alienated from others and their environment.

When applied to Aboriginal Australians it is proposed that this population may have a high external locus of control. This may therefore predispose Aborigines to increased levels of mental
illness, which, if combined with the high levels of trauma and generally poor physical health and low life expectancy, may indicate a major health problem which is as yet unquantified. High external locus of control may have implications for how mental illness is socially constructed, lending weight to more external or magical explanations of psychopathology. Many aberrant behaviours are seen to be “affected by external causes” and individuals are “not held responsible for their actions” (Swan Pt2 1995 p30). Finally high locus of control may also have implications for the management and treatment of mental illness, responsibilities for medication and therapeutic interventions. This would highlight the efficacy of traditional healing practices and family interventions for managing psychiatric disabilities. However we would hasten to add that this thesis is highly conjectural, and requires further research.

Cultural transference

However we might like to characterise the difference between cultures, and the process of working together across a cultural divide in remote Aboriginal communities, we have to decode, or at least become aware, of the process of transference and projection in such relationships. This is the subject of Craig San Roque’s paper “Black and White and the ‘Things Between Us’, Some Ideas on the Psychology of Cultural Relationships” (San Roque 2002).

Craig is a psychologist and therapist who has spent many years working with Aboriginal people in Central Australia. Deriving from the work of Freud and Jung, Craig explains that transference is “about the way emotional reactions, images and ideas behave between people and about how we shift such feeling/ideas about between us”, and that projection is “the way human beings send mental and emotional images and messages to each other” (2002 p32). These processes are of course often quite unconscious, and can be embedded in communication patterns, emotions, expectations and beliefs. He argues that it is vital to try and “decode and interpret” these processes in order to make the therapeutic relationship more productive.

Cultural stress

According to Tracey Westerman, an Aboriginal Psychologist from WA, one of the most significant factors which accounts for bias in assessment or testing in mental health is cultural stress. She developed two very simple tools for “Sense of Culture Scale” and “Culture Stress Scale”, which would enable clinicians to identify and therefore incorporate these elements into their assessments. The two scales are important because, for example, a so-called ‘urban Aborigine’ may have a high level of cultural stress and relatively low sense of culture, compared to say a more traditional remote based Aborigine. These scales therefore attempt to appreciate this dynamic. The stress of negotiating and existing between a western colonial culture and traditional culture can cause huge amounts of pain, not adequately encapsulated by reference to the diagnosis of an “adjustment disorder”.

Related to cultural stress is trauma and grief, “identified as amongst the most serious, distressing and disabling issues faced by Aboriginal people” (Swan Pt1 1995 p3). Suicide and self harm is another manifestation of massive cultural stress (Swan 1995 p5). As such clinical Mental Health Services needs to work in partnership with Life Promotion programs that may focus on community development.

In addition there is an emerging understanding of how stress and indeed trauma can cross generations. Veterans bring the disaster of war back to their families and children, who in turn can pass on problems to the next generation. The violence of the Holocaust or the Stolen
Generation can be transmitted over the generations in “layered pain”, dealt with by holistic therapies (Atkinson 1997).

**Culturally appropriate practice**

Only 10% of non-Indigenous practitioners feel confident working with Aboriginal mental health (Westerman 2000 p12). In Central Australia the Sheldon Remote Mental Health Team is committed to delivering services in a culturally appropriate manner, but this is often limited, and depends on the commitment of individuals rather than that of the organisation (in terms of resources and training). Drawing on the literature, Westerman defines a continuum of cultural competence ranging from: aversion, incompetence, blindness, precompetence, competence and proficiency. Aversion may be intentionally destructive or even racist. Incompetence may be destructive, but not necessarily intentional. Cultural blindness may be well-meaning, but tends to be oblivious to cultural difference.

**Cultural sensitivity or precompetence**

This seems to be the stage where most workers in the field feel they are at. It implies an awareness of personal limitations, but frustration at a lack of knowledge to adequately deliver services in a culturally appropriate manner. At this stage there is an “acquisition of knowledge of a particular culture’s values, attitudes and beliefs as well as practices.” (Slattery 1987) At this stage there may be some increased skill and awareness about body language and cross cultural communication, working with kinship networks, and using cultural consultants. Most important is being aware of one’s limitations and being clear about roles and responsibilities. The visiting mental health practitioner can only ever work as a consultant or adviser about treatment. The real work is done by the families, local clinic, health workers, and community supports.

**Cultural competence and proficiency**

According to Westerman this stage should be the “minimum level for good practice” (2000 p13), but sadly most practitioners would probably tend to get to the previous stage, and perhaps just start to become more competent before then leaving the service out of frustration and lack of organisational support. For Slattery (1987) this stage refers to the acquisition of real skill to carry out cultural translation of a service. This may mean competence utilising cultural consultants well, and modifying communication and counselling techniques to suit the other culture. Proficiency may even involve fluency in the other culture’s language.

**Assessment tools**

It is a frustrating reality that many of the assessment tools utilised by clinicians in mental health often have little or even no cross-cultural validity. Our basic stock in trade, the Mental Status Evaluation and the Mini-Mental Status, and the diagnostic criteria we use to decide on treatment can all be sadly lacking. In our clinical practice we might feel that there is some dimension missing from our assessments, or that we may even be at cross purposes. The trouble is we do not want to stray too far from the standard tools and diagnostic criteria, lest we fall into cultural relativism, and our tools become totally subjective. We know too that many such tools have been used for a long time and extensively validated in our own cultural-historical context, so we do not want to throw the baby out with the bathwater.
However there may be a middle ground where the various assessment tools can be modified to make them more culturally sensitive. A lot of work is already being done in this area such as by the World Health Organisation (Sartorius and Janca 1996), but it is very preliminary. One of the few, if not the only, Aboriginal Psychologists, Tracey Westermann from WA, is developing a few assessment tools which have been exhaustively validated. This includes a Suicide Risk Schedule and the WASC (Westerman Aboriginal Symptom Checklist) for Youth, and she is developing a similar tool for adults. These tools do not totally change all the criteria we might expect in a risk assessment, but more highlight or emphasise particular elements which are important in assessing Aboriginal clients. For example in the level of impulsivity, and the importance of cultural stress.

Other tools too can be easily modified, such as even the Mental State Examination (Sheldon 1997). Singh does this well (Singh 2000) in his “BASSICS ID” model. In this acronym he adds other elements to bring out aspects which may be more significant for Aboriginal clients: Behaviour, Affect, Sensations, Strengths, Imagery, Cognition, Spiritual, Interpersonal relationships, and Drugs. Sheldon in his thesis also explores many aspects of the MSE and making it more culturally valid (1997 p36f). The Sheldon Remote Mental Health Team developed its own version of a more culturally valid Mental State Examination, “ABC PAC SCORD”: Appearance, behaviour, conversation, perception, affect, cognition, spirituality, culture, organic, relations, drugs’. The “ABC PAC” follows the standard MSE format. The “SCORD” attempts to encapsulate important cultural data. “Spirituality” and “cultural” factors are considered distinct areas that require elaboration or assessment. “Organic” attempts to address co-morbidity issues, such as diabetes, hypertension etc. as they may impact on mental health. “Relations” attempts to get a picture of the client’s kinship connections and how this may be important for their support, or as a source of stress (for example family discord). “Drugs” of course highlights dual diagnosis issues, and indicatessubstance abuse factors.

Cognitive impairment may involve a modified mini-mental, taking into account more culturally accepted norms for orientation, such as knowing directions and naming places and family members. While literacy and numeracy may be an issue, one can deduce significant impairment for example, if a client no longer plays cards (a common game in Aboriginal communities, requiring a high level of cognitive skill). There are also various other assessment tools which focus on more visual-spatial cognitive skill, such as the Rey Complex Figure, or the Raven’s Standard Progressive Matrices, and are more cross-culturally validated.

### Cultural consultants

The Cultural Consultant or Aboriginal Mental Health Worker (AMHW) acts “as a ‘guide’ to the culture, its beliefs and practices” (Slattery 1987 p 62, Westerman 2000 p33). That person is usually Indigenous to the community where one is working, and acknowledged, or even selected, by the community to be in that role. They are more than just an interpreter in the local language. They usually also have extensive knowledge of a client’s family, cultural factors that may impact on that person, and know key family members, supports, or traditional practices that my assist that client to recovery. The training and role of the AMHW is a key component of Ways Forward (Swan Pt 1 1995 p3), and recommends that there should be a “minimum of two mental health workers—one male, one female—in each region” (Swan Pt 1 1995 p30).

However there can be various pitfalls in the use of cultural consultants, which the barely culturally competent can face. The most typical mistake is enlisting a consultant for the wrong cultural group, just having an Aboriginal face in an interview does not mean it will be appropriate. Other problems include (Westerman 2000 p34): gender, avoidance relationships, family conflict, or one
not considered appropriate for that particular problem, or one not acknowledged by the community to act in that role.

**Role of the psychiatrist**

In Western medicine the Psychiatrist is usually the clinical ‘leader’ of the multi-disciplinary team. In Aboriginal culture great respect is payed to “doctors” who can be perceived as “ninti pulka Ngangkari” (Pitjanjatjara) or very clever healers. The Psychiatrist therefore could very much be equal status to the Ngangkari (see later) of traditional society. The Psychiatrist therefore should have the flexibility that in cultural or spiritual matters the Ngangkari may well be the authority, and should be recognised and acknowledged as such, and subsequently be involved with case conferences and clinical discussions. They may well be a secondary adviser in this context.

**Prevention, promotion and early intervention**

Working holistically often means focusing not on the individual client, but at the family, community, or structural/community development level. Community capacity building probably aims at those fundamental elements mentioned in the Recovery model: housing, education, income, work, and general health. Wherever possible the SRMHT aims to enhance these vital elements of community, by working with the various agencies and supports in the community support base. This may at first glance appear to be an unrealistic and overwhelming task, when the emphasis is on clinical work.

However by supporting the role of Cultural Consultants or Aboriginal Mental Health Workers, the Mental Health Services not only makes its job easier and more culturally appropriate, but also can effect real community change at a structural level. Supporting the development of a network of AMHWs in various communities touches on all the above elements (except perhaps housing). It connects people to education, can bring in income and real work, and bolster broad health outcomes. At the grassroots level it facilitates case management and early intervention by having workers who live and work on communities. It also provides opportunities for projects like the Yuendumu Respite House, which provides prevention and promotion activities, as well as a therapeutic venue for client or family respite and support—thereby often preventing admission to hospital. In Central Australia there are currently three full time, paid, cultural consultants or AMHWs, and through the Division of GPs there may be another two or three workers in the field. Another such worker may be funded by SA to work across the border in the Anangu Pitjanjatjara Lands.

**Traditional healing practices**

Aboriginal people have thousands of years of tradition and practices in dealing with many illnesses and ailments. Traditional languages incorporate many complex and subtle terms to describe ‘mental illness’ or mental states (Sawn Pt 2 1995 p30), although it is important to realise that these terms may be more collectivist in meaning (Andary 2003 p56). However it is recognised that many problems are ‘new’, or have been introduced with colonisation.

**Foods and medicines**

There is a huge cornucopia of traditional foods and medicines for many ailments and illnesses (Latz 1995). These are well documented by botanists, and it is known that many may contain some active ingredients for treatment of different problems. However I am only aware of one
Clinic that actively encourages the collection and storage of bush medicine for local use. This practice not only serves to preserve traditional knowledge, but also can foster small scale local industry. Bush medicines that may assist in the treatment of mental illness may be a fascinating area for further study and documentation. One case in point is the role of substances like “mingkulpua”, pituri, or bush tobacco, and its narcotic properties. Other bush medicines identified for madness or headaches include: rock fushia, bush banana, bush current, lemon grass and quondong (Swan Pt 2 1995 p32; Dunlop 1988 p129–134).

Traditional healers or Ngangkaris

Many Aboriginal people in Central Australia would consult a traditional healer or Ngangkari as a matter of course, often even before going to the local clinic or utilising western medicine. They exude great authority and power in the Aboriginal community. They are consulted with all sorts of ailments, physical or psychological. Many of the most powerful Ngangkaris seem to be men, but women also can be Ngangkaris in their own right. Elkin describes this tradition in detail in his classic book *Aboriginal Men of High Degree* (Elkin 1994). NPY Womens Council describe the role of the Ngangkari (in Thomas 2000 p5) as follows:

A Ngangkari is a very clever person—they know all about sickness—they can look inside and see their sickness. They can look and see that someone is unhappy or mad or something is wrong with their head, from looking at their face...and they will touch his head and hold it tightly, and pull something out of his head, it might be a stone or a stick, or a mamu (bad spirit) inside making him crazy. Then at night when the Ngangkari is asleep, his spirit might go to that young fella’s place and go inside his head and fight with that mamu and pull it out and get rid of it. That young fella will wake up and think, ‘Oh I’m happy, I’m feeling good, my head is no longer heavy—that mamu is gone’.

NPY Womens Council recently published a wonderful book on Ngangkari work (NPY, Womens et al. 2003). Particularly with mental health issues, the role of the Ngangkari may be considered more significant than that of non-Indigenous interventions. Moreover ‘spiritual causes are “often applied to the more severe cases” ’ (Swan Pt 2 1995 p30). It is therefore incumbent on Mental Health Services to not simply act with tolerance, but to work in active collaboration with traditional healers: encouraging access to the inpatient unit and treatment planning; assisting in locating Ngangkaris for clients; and assistance with payment for their services (often including extensive travel). More generally they need to be acknowledged and recognised for their status as doctors of the soul. However Ngangkaris can also have their limitations, saying that they are powerless against such introduced syndromes as petrol sniffing, because such people are seen as spiritually deficient and unable to treat (Swan 1995 Pt2 p30; and anecdotal).

Culturally bound syndromes

The DSM IV outlines in its Appendix I a glossary of culturally bound syndromes. The ICD 10 classification includes “neurasthenia” as a diagnostic category which has considerable “cultural variations” (F48) (Andary, Stolk et al. 2003 p52–54) In the DSM apart from the syndrome called “amok” or “running amok”, characterised by a “period of brooding followed by an outburst of violent, aggressive, or homicidal behaviour...” there are no other syndromes which might be applicable to Central Australia. Nor are any of the syndromes listed which are said to be derived or known to occur among Central Australian Aborigines. Sheldon also did not find any evidence of culture bound syndromes (1997 p44). However there is anecdotal evidence that specific culturally bound syndromes can or do exist among Aborigines. These include, for want of terminology and further description: pay back fear; voluntary mutism after trauma; transgression of cultural Law states; possession states (Swan 1995 Pt 2 p34) and most prevalent, “being
sung”—resulting in all sorts of physical and psychological manifestations. While there are instances where depression, psychosis, or somaticisation may be at work in some cases, there are certainly many instances where this diagnosis is not warranted, and the primary driving force of the syndrome is sorcery, magic, or some kind of paranormal cultural belief. We should also be aware that western psychiatric categories are to some extent culturally constructed (Andary et al 2003); and that some disorders in the DSM categories could well be defined as “culturally bound” in western society, such as anorexia nervosa, or chronic fatigue syndrome (Ibid p10 7 19).

One of the important roles of the Cultural Consultant is to elicit these kind of syndromes, and offer support and referral to Ngangkaris, or other cultural interventions, as required.

**Building therapeutic alliances**

**Narrative therapy**

Narrative Therapy is proposed as the most culturally appropriate form of approach for working with Aborigines, particularly in remote areas. It is of course a therapeutic approach that has been developed over many years, emerging from systems and family therapy, and the work of Michael White and David Epston (Freedman 1996). The applicability of this form of therapy in working with Aboriginal people was consolidated in the work of Wingard and Lester (Wingard and Lester 2001). Narrative therapy incorporates a sophisticated critique of the scientific and medical paradigm, but in practice “Narrative focuses on people’s own descriptions of their lives. It invites an examination of the ‘problem’ as understood by the client and their community rather than a preconceived professional ‘assessment’” (Aguis and Hamer 2003). This approach also dovetails with Andary’s “edic” approach to mental health assessment in cross cultural situations (Andary, Stolk et al. 2003). As such it is based on the client’s ‘story’ and preferred way of “being in the world”, and not a professional interpretation or preconceived view of what is ‘healthy’.

Essential elements of Narrative Therapy include: links to history; the importance of relationships; a story-telling approach; connectedness; and a holistic approach.

Furthermore “Narrative can work in partnership with mainstream psychiatric and psychological services to enhance mental health outcomes for Indigenous people.” (Aguis and Hamer 2003 p9) Embedded in the client’s ‘story’ is always some kind of problematic behaviour or malady, which may be recognised by the clinician in terms of a traditional western psychiatric constructions, or it may be more culturally bound. Good diagnosis and assessment is therefore still vital. However management of that behaviour or ‘illness’ ought to be externalised, rather than internalised (such as one might do with a client from a European cultural background with a high internal locus of control). In the context of this dialogue a specific Narrative technique that has a good ‘fit’ with the Indigenous construction of self is externalisation. This can be applied to many different forms of problematic or pathological behaviours, such as anger management, suicidal ideation, depression and even psychosis. The behaviour is externalised as a “mamu” (monster), bad spirit, cheeky dog, or other such manifestation or metaphor that is meaningful for the client. Strategies for dealing with that behaviour can then be explored, which involve a focus on strengths and solutions, and emphasise the role of family, Ngangkaris, magic and medicine. Just as an aside in our experience, perhaps contrary to popular opinion, Aboriginal people may have a high regard for medication and its role as an external agent for managing a problem. It is usually the person with a high internal locus of control that says ‘I don’t need this medication, I can manage this problem or illness myself’. Non-compliance in Aboriginal communities may be more to do with a failure on clinician’s part to identify appropriate family obligations that may facilitate compliance,
or not recognising (and utilising) the intrinsic role of Aboriginal Health Workers who have been sanctioned by the community to assist with medication. Alternatively non-compliance may have more to do with social disintegration than anything intrinsic to Aboriginal community. As such this offers an opportunity to build on the strengths of Aboriginal society, by acknowledging the important role of an auntie or uncle for example, rather than undermining those social roles by dependence on the clinic.

**Brief solution focused and cognitive therapy**

In our experience interventions are often brief and intensive, when a client is in a ‘crisis’ situation. This is usually when the client has come to hospital or going through and acute episode. Following from the crisis intervention literature, this of course is also the time when change is most possible. At other times the prevailing attitude is simply that “(s)he’s right”, as though there is nothing for one to do, or no role. When in fact this is an ideal time to focus on building relationships and enhancing ‘recovery’, or working on prevention and promotion strategies. This may be more of the role of the AMHW with the clinician acting as consultant. However the acute episode is often an opportunity for significant intervention.

Like Narrative Therapy, Solution Focused Therapy tends to emphasise the client’s strengths and positives, rather than dwell on the ‘problem’. It tends to use some key questions, or invitations, to assist the client to focus on solutions rather than problems, such as the ‘miracle’ question.

**Psychoeducation**

In our experience European health workers grossly underestimate the capacity of Aboriginal people living in remote areas to understand the nature and purpose of (western) diagnostic formulation or treatment that is proffered. Perhaps this is due to cultural and language differences, or possibly it is just laziness on the part of European health workers or simply having no time in a busy clinic to explain things, or more insidiously it could be a part of the legacy of passive welfare and health mentality of our colonial history.

In recent years there have been a lot of materials ranging from renal disease to alcohol and drug abuse that attempts to redress this balance. A case in point is the “Brain Story” which deals with the problem of petrol sniffing in a way that is appropriate to Aboriginal tjukulpa or story-telling approach. In our view these materials are only a beginning. There is huge scope in making basic western psychopathology and pharmacology more intelligible and meaningful, and thereby increasing health outcomes and compliance. Sheldon makes it clear in his thesis (1997 p43f) that the “major syndromes (schizophrenia, major depression, bipolar disorder, dementia) were frequently present and usually easily recognised”. But more importantly Aboriginal people and families of sufferers could “quite pragmatically accept a multi-factorial explanation for a mental disturbance and accept multi-modal management eg medication for the biological side, to see a Ngankari for the psychological spiritual side and to mobilise family supports for the social side.” (Sheldon 1997 p44) He went on to conclude that in the management of mental illness psychoeducation, through the mode of storytelling, is a vital strategy.

It should be understood that “compliance” with treatment, whether it is in mental health or general health, is not just a medical issue. It is “irrevocably connected with interactional issues of cultural sensitivity, communication and time, with organisational and ideological issues of biomedical power and frameworks of thought and practice, and with structural issues of poverty, dispossession, marginalisation and institutionalised racism.” (Humphery, Weeramanthri et al. 2001 p26) As such this needs to be addressed as a partnership. Aboriginal people want fair
access to western medical treatment. They also want to preserve their own traditional healing practices, and most importantly they want this joint approach to be community based (Moreen 1993; Sambono 1993). Whether it is counselling or medication these services can be mediated through the appropriate relationships, and cultural context.

**Ecopsychology**

Hunter outlines a fascinating “sociohistorical frame” to explore the changing metaphors and approaches to Indigenous mental health from the 1950s to the 1990s (Hunter 1997). In that framework Psychiatry itself has undergone a change of perspective to meet changing historical trends, and even political pressure, moving from the psychopathology of the exotic (1950s); through ethnopsychiatry (1960s); and then in the 1970s incorporating a social disadvantage perspective, and finally adopting a historical and political framework in the 1980s (Hunter 1997 p822). The 1990s he writes: “an Indigenous politically and culturally informed construction of health and mental health is emerging” (Hunter 1997 p824). But how does Psychiatry and Mental Health Services meet this challenge?

I would suggest that the field of Ecopsychology holds promise to meet such a challenge and provide a paradigm for psychiatric practice into the new century, particularly in the area of cross cultural and Indigenous mental health. It seems to me to be the most natural paradigm that can incorporate all the elements we have been discussing in this paper, and still retain a distinct sense that we are still ‘doing’ Psychiatry.

Ecopsychology is not really that new. The basic premise is that the ‘mind’ is not just something between the ears, but is dynamically integrated with the physical and social environment. Gregory Bateson was arguing this in 1972 (Bateson 1972), and Theodore Rosak has attempted to pull together a diverse range of psychologists, ecologists, and thinkers from many walks of life into this approach in *Ecopsychology* (Roszak, Gomes et al. 1995).

The usefulness of Ecopsychology for our purposes is that it can offer a paradigm that can draw many of the threads of our discussion together into a cogent whole. It easily incorporates the more holistic approaches of the recovery model and social and emotional well-being, and embraces Narrative Therapy and Traditional Indigenous Healing practices. It is also grounded in a “psychology as if the whole earth mattered”, connected with the current environmental crisis and the deep ecologists view of the mind being embedded in land. As such this approach would not be at all alien to the Indigenous ‘Mind’. Ecopsychology also invites self-reflection, and a genuine capacity for empathy with Indigenous culture.

**Conclusion**

“Leave Only Footprints” is an evolving document, and as a statement of the philosophy and practice of the Sheldon Remote Mental Health Team, it is only a beginning. We have attempted to bring together many elements that have been gleaned over recent years, and identify issues and dilemmas that require more critical reflection and research. Some of these issues require political commitment, and basic resources to implement. This would be more the subject of a Strategic Plan. Other elements require more research and investigation, in particular the basic epidemiology of mental health in remote Aboriginal communities, and the evaluation of the kind of approach outlined in this paper.(Sheldon 1997; Hunter 2002; Andary, Stolk et al. 2003)
References


