Working Together: to enhance Aboriginal Mental Health and Wellbeing

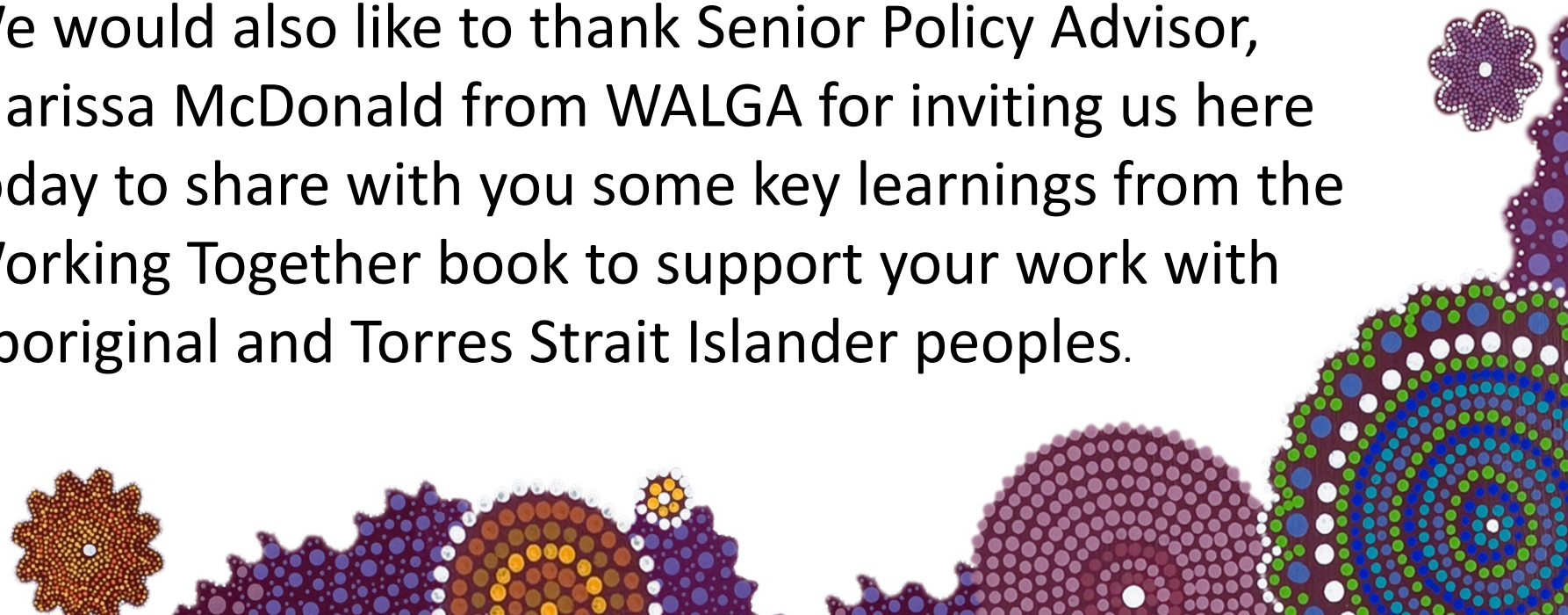
Roz Walker & Pat Dudgeon

WALGA Local Government and Mental Health Forum
The Boulevard Centre
Floreat
11 November 2019

Acknowledgements

We would like to acknowledge and pay our respects to Whadjuk Noongar Elders, past present and emerging and the traditional owners of this beautiful boodja.

We would also like to thank Senior Policy Advisor, Marissa McDonald from WALGA for inviting us here today to share with you some key learnings from the Working Together book to support your work with Aboriginal and Torres Strait Islander peoples.



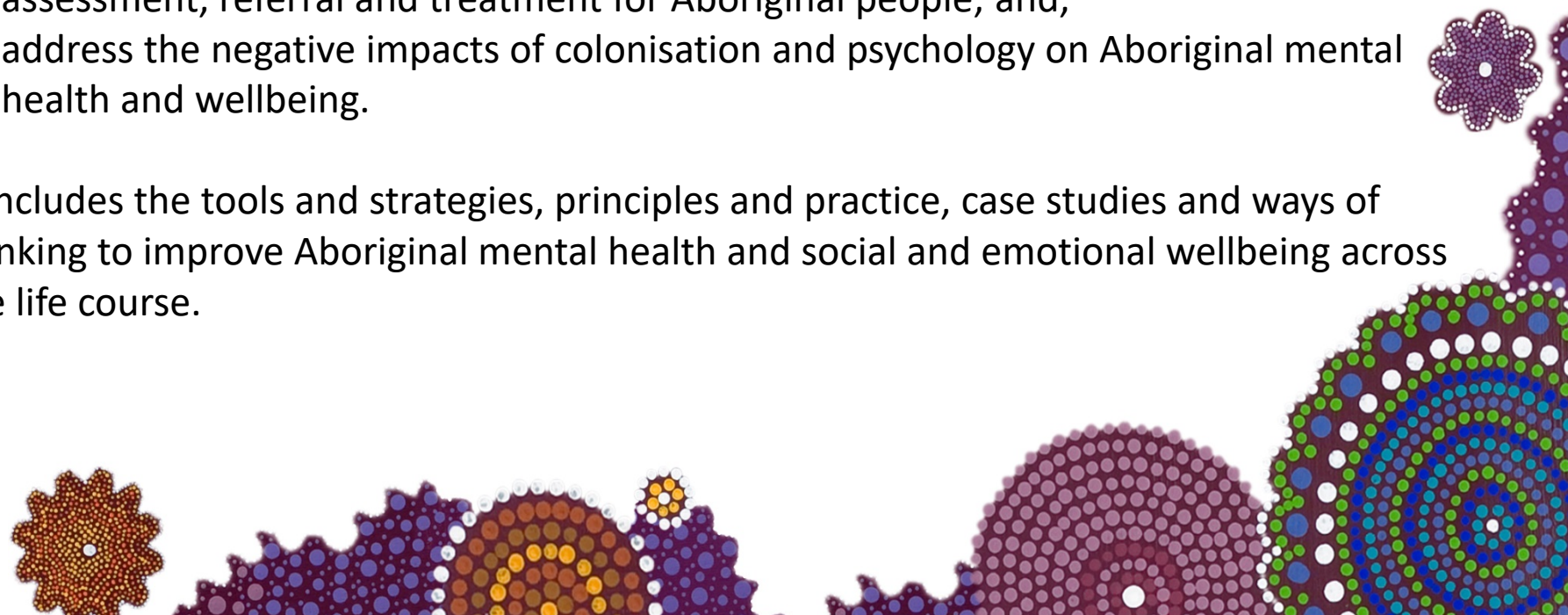
Aim

This presentation describes the research journey involved in the development, implementation, strategic promotion, dissemination and evaluation of the 1st and 2nd editions of *Working Together book*. Developed as part of the COAG initiative the book is about decolonising mental health disciplines and professional practice.

The book aims to:

- increase the knowledge, understandings and skills of the mental health workforce and all relevant services to provide more effective, culturally competent engagement, assessment, referral and treatment for Aboriginal people; and,
- address the negative impacts of colonisation and psychology on Aboriginal mental health and wellbeing.

It includes the tools and strategies, principles and practice, case studies and ways of thinking to improve Aboriginal mental health and social and emotional wellbeing across the life course.



Background

The Working Together book was initially conceptualised and developed as an important resource for Aboriginal Health workers, allied health professionals, counsellors and clinic staff in Indigenous specific health and mental health services.

It was one of five Indigenous specific measures supported by the Council of Australian Governments (COAG) in 2007 as part of the Mental Health Initiative to reform of Australia's mental health system over five years through the Office for Aboriginal and Torres Strait Islander Health (OATSIH).

OATSIH was responsible for the administration and implementation of the Indigenous-specific measure ***Improving the Capacity of Mental Health Workers in Indigenous Communities***

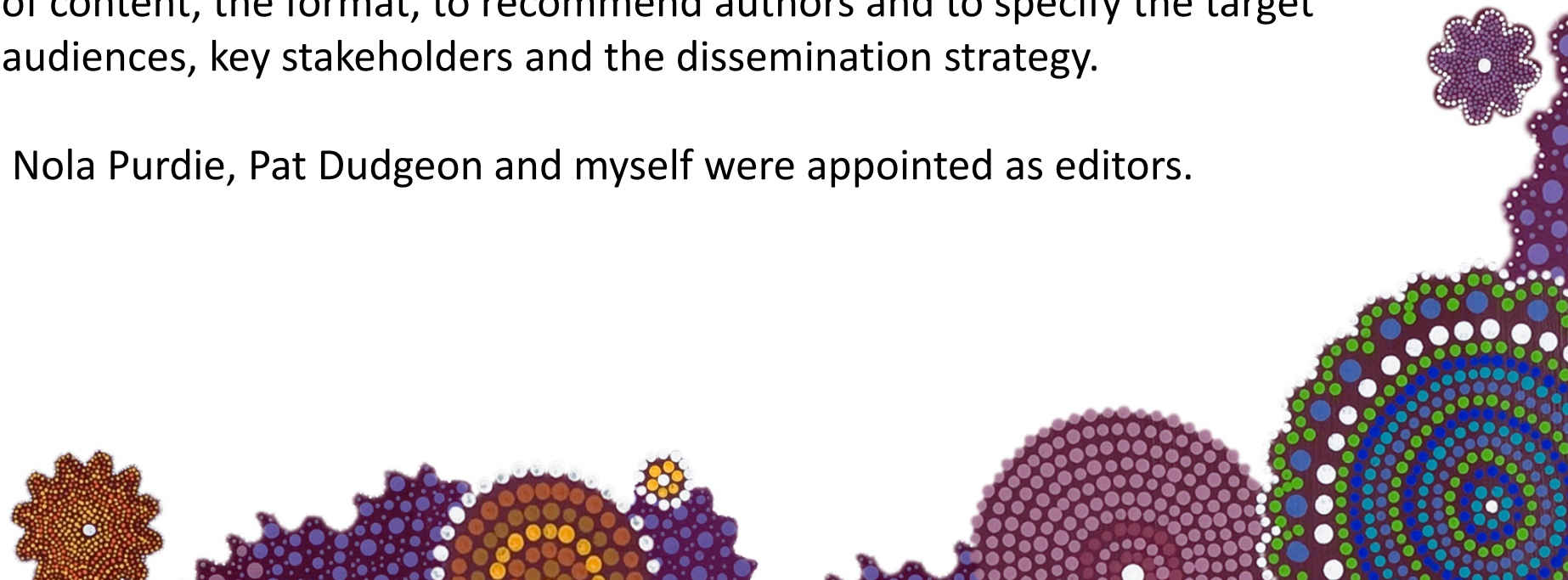
Working Together has proved to be a highly successful in achieving the COAG aims

Background

The 1st edition was a collaboration between the ACER and Kulunga (we were subcontracted to provide Aboriginal input and responsible for establishing an internal reference group.

OATSIH also appointed a high level expert reference group to oversee the five initiatives and guide the development of the book – to determine the scope of content, the format, to recommend authors and to specify the target audiences, key stakeholders and the dissemination strategy.

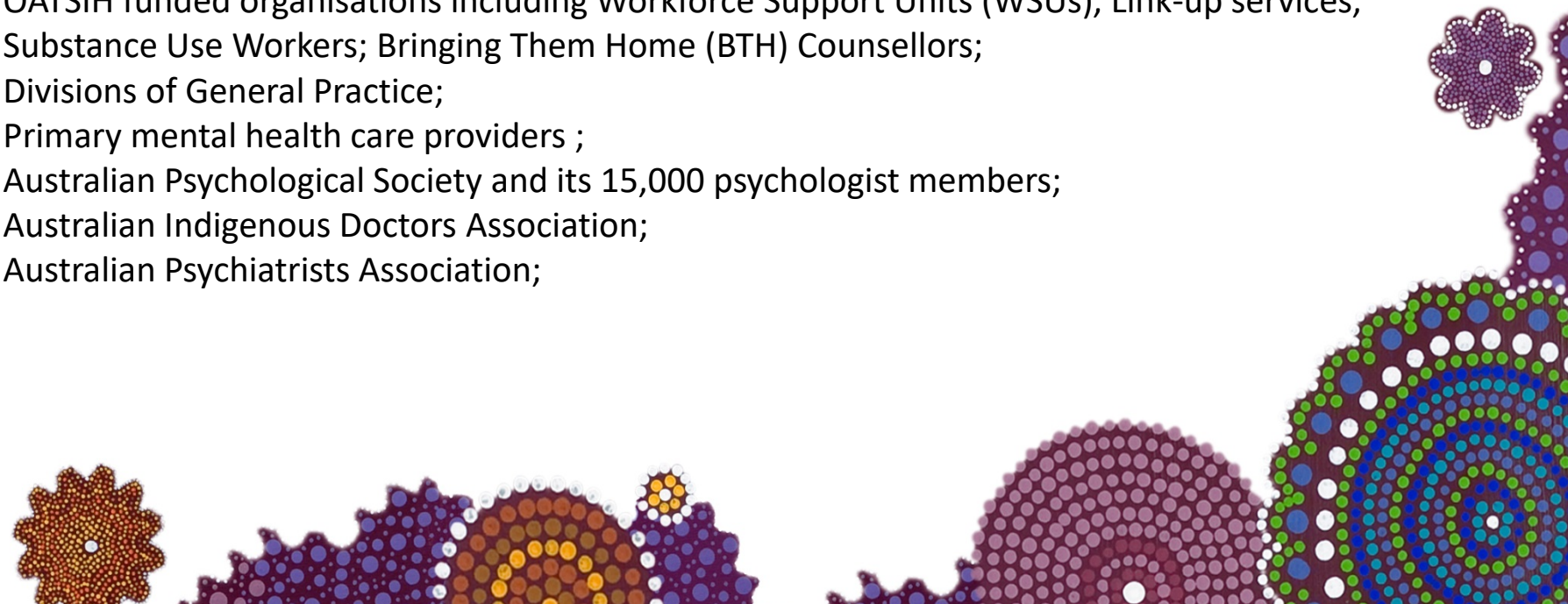
Nola Purdie, Pat Dudgeon and myself were appointed as editors.



Key Stakeholders

Key stakeholders consulted throughout the development of the book included:

- Universities undergraduate and post-graduate courses in Health, Mental Health, Psychology, Nursing and Social Work and Aboriginal health;
- Aboriginal Health Worker education providers;
- State mental health services, including community health and tertiary treatment services;
- Medical Institutions including tertiary hospitals;
- Aboriginal Community Controlled Health Organisations (NACCHO) affiliates;
- OATSIH funded organisations including Workforce Support Units (WSUs), Link-up services, Substance Use Workers; Bringing Them Home (BTH) Counsellors;
- Divisions of General Practice;
- Primary mental health care providers ;
- Australian Psychological Society and its 15,000 psychologist members;
- Australian Indigenous Doctors Association;
- Australian Psychiatrists Association;



Key Stakeholders (cont)

- Australian College of Mental Health Nurses;
- Royal College of Nursing Australia;
- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN);
- Royal Australian and New Zealand College of Psychiatrists;
- Royal Australian College of General Practitioners;
- Australian Association of Social Workers;
- Mental Health Council of Australia;
- Australian Indigenous Allied Health Association;
- Allied Health Professions Australia;
- Services for Rural and Remote Allied Health Professionals Australia;
- Australian College of Rural and Remote Medicine;
- Vocational Education Training (VET) institutions;
- (Professional associations;
- Aboriginal Medical Services (AMSs)

The First Edition

The book was produced over 18 months with three major meetings with expert panel who reviewed every chapter.

As a result of the consultations we developed a book with 21 chapters, and five sections underpinned by the guiding principles of the social and emotional wellbeing Framework.

It was described as '*a milestone bringing together Aboriginal voices, new principles and strategies and new ways of working with Aboriginal individuals, families and communities.'*

attempting to encompass and address the social and cultural determinants impacting on Aboriginal mental health, and illustrate Aboriginal conceptions of social and emotional wellbeing as being distinct from mainstream conceptions..'

Getting over the line

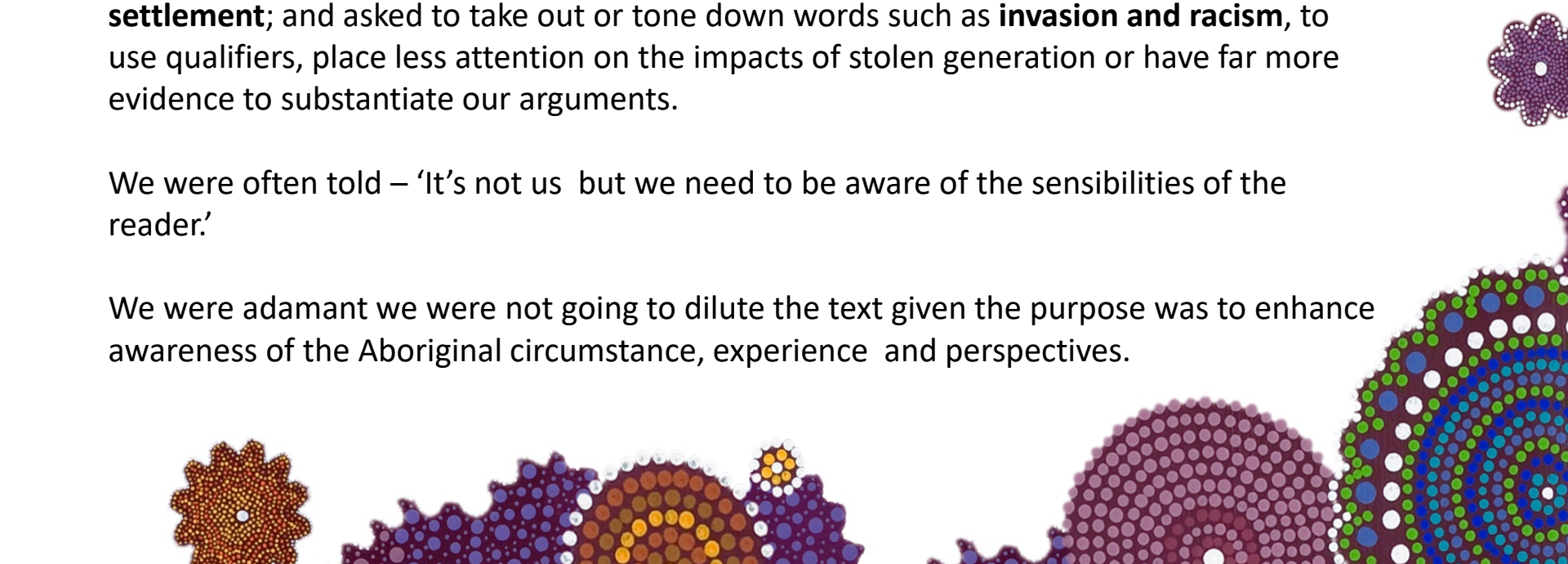
There were significant challenges during the production of the book. It had to be cleared by five commonwealth departments, approved by the Chief Medical Officer in Canberra and reviewed by over 60 senior policy officers in all branches in OATSIH, Health, (including alcohol and substance use, FASCHIA, DEET) and signed off by two Ministers.

We had to surmount incredible stumbling blocks - often revealing the very systemic racism we were trying to shift.

For example - we were asked if we could include the phrase '**so called colonisation**' or **settlement**; and asked to take out or tone down words such as **invasion and racism**, to use qualifiers, place less attention on the impacts of stolen generation or have far more evidence to substantiate our arguments.

We were often told – 'It's not us but we need to be aware of the sensibilities of the reader.'

We were adamant we were not going to dilute the text given the purpose was to enhance awareness of the Aboriginal circumstance, experience and perspectives.



Getting over the line

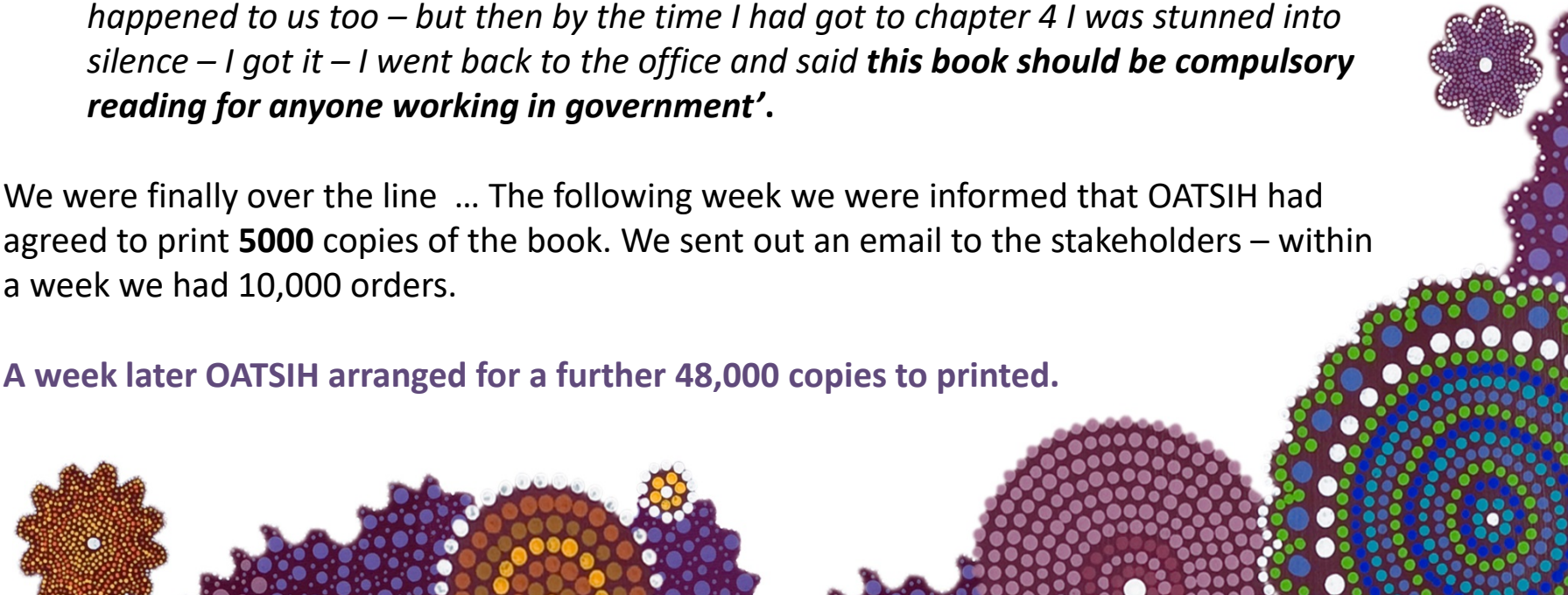
We sent the book to four universities to be 'market tested'. Lecturers used various chapters with students and read the book themselves to determine its readability and relevance as a text. The feedback was very positive – we used the market testing and feedback from the expert reference to support our position and argument with OATSIH.

Finally a key person in OATSIH at the time rang me to say they had taken the book home to read it over the weekend saying something along the lines –

> *'at first I was having a dialogue or more correctly an argument with each chapter – resisting the message – my family were migrants so I found myself saying well that happened to us too – but then by the time I had got to chapter 4 I was stunned into silence – I got it – I went back to the office and said* ***this book should be compulsory reading for anyone working in government'.***

We were finally over the line … The following week we were informed that OATSIH had agreed to print **5000** copies of the book. We sent out an email to the stakeholders – within a week we had 10,000 orders.

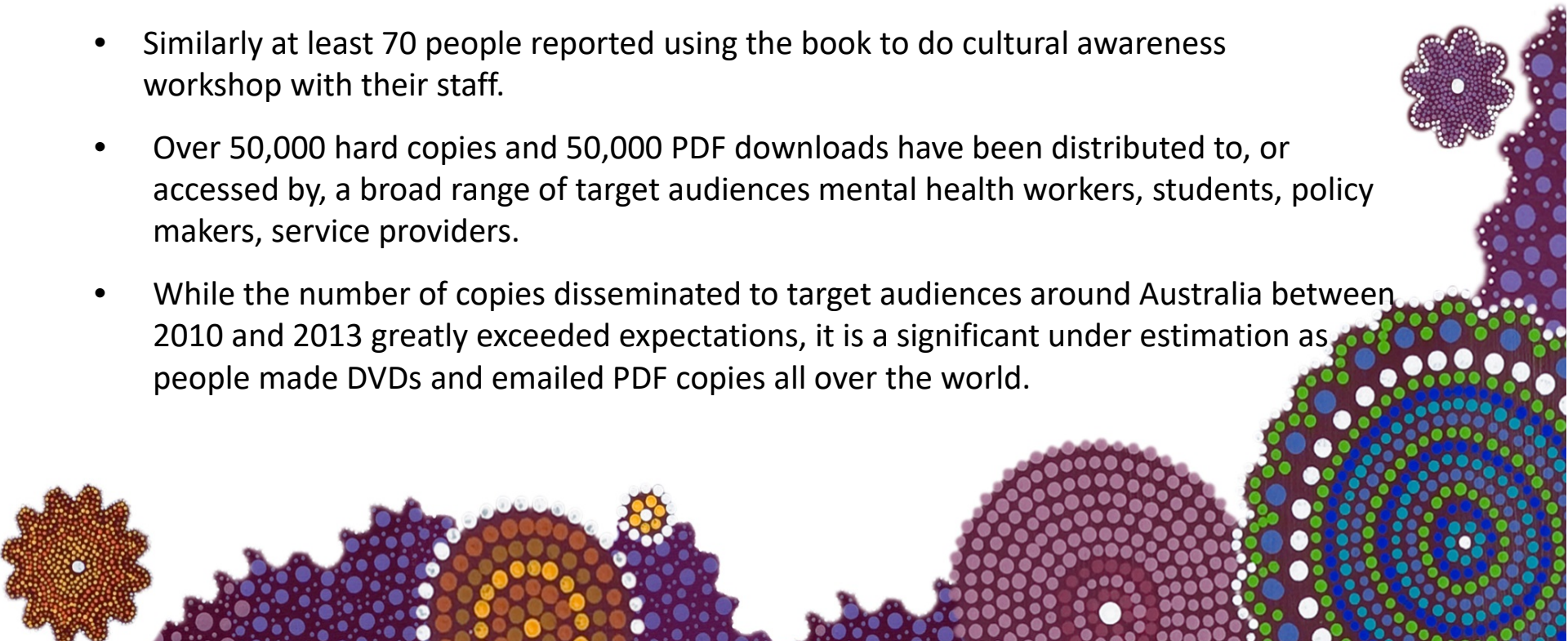
A week later OATSIH arranged for a further 48,000 copies to printed.



Dissemination Strategy

A targeted strategy was developed and implemented for all VET providers in the areas of: Aboriginal and Torres Strait Islander Health Worker training; ASEWB counsellor training and Mental Health Worker training.

- The book was presented at over 24 national and international conferences and seminars and 26 workshops.
- Aboriginal psychologists from AIPA also presented chapters from the book as part of the Cultural Competence workshops to over 1200 psychologists in the first year.
- Similarly at least 70 people reported using the book to do cultural awareness workshop with their staff.
- Over 50,000 hard copies and 50,000 PDF downloads have been distributed to, or accessed by, a broad range of target audiences mental health workers, students, policy makers, service providers.
- While the number of copies disseminated to target audiences around Australia between 2010 and 2013 greatly exceeded expectations, it is a significant under estimation as people made DVDs and emailed PDF copies all over the world.



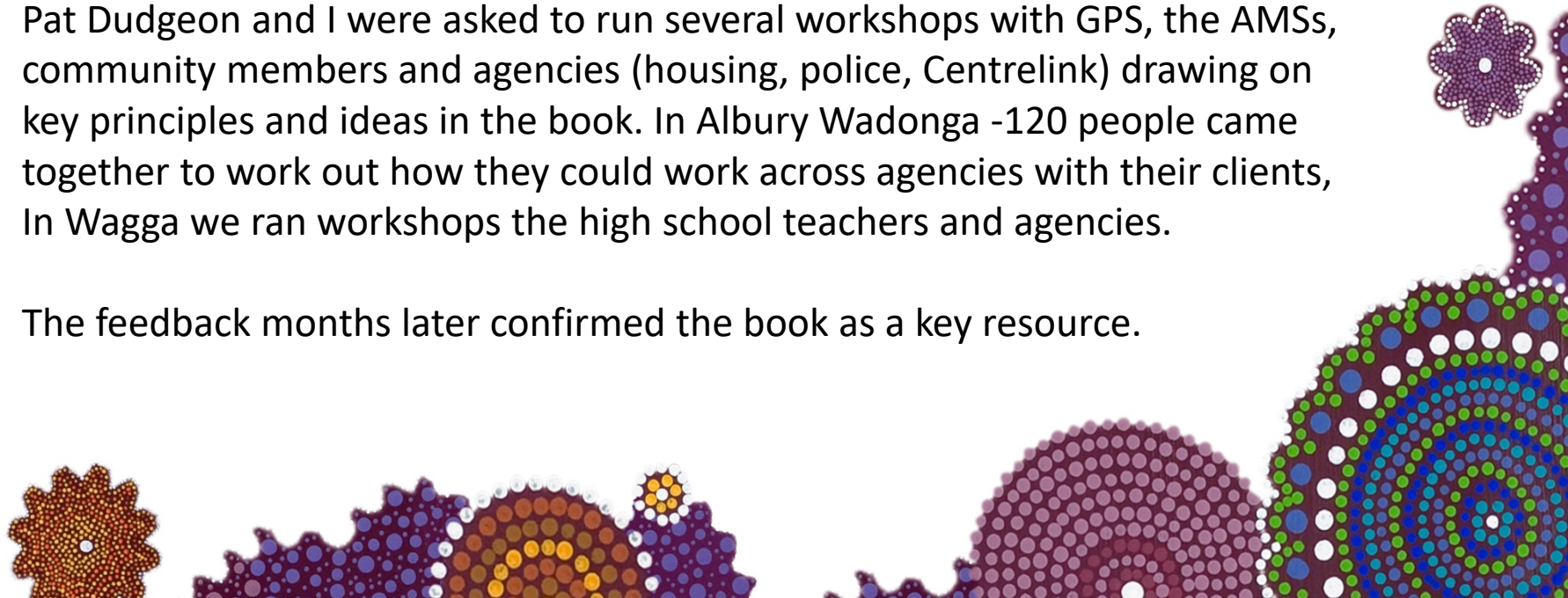
Making a difference

Over the following months we started gathering the evidence that the book was really making a difference in the way practitioners understood the issues for Aboriginal people.

The CC workshops included pre and post testing and many people reported back that their organisations had implemented new strategies and protocols for working with clients.

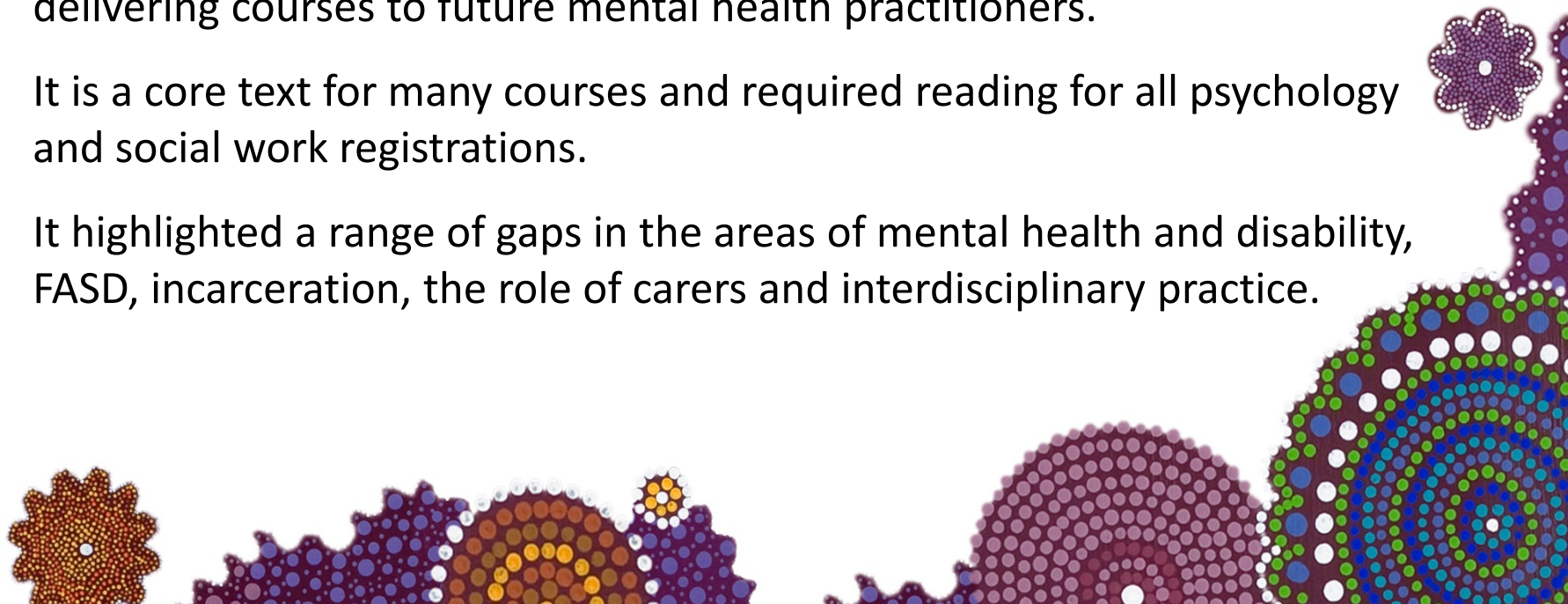
Pat Dudgeon and I were asked to run several workshops with GPS, the AMSs, community members and agencies (housing, police, Centrelink) drawing on key principles and ideas in the book. In Albury Wadonga -120 people came together to work out how they could work across agencies with their clients, In Wagga we ran workshops the high school teachers and agencies.

The feedback months later confirmed the book as a key resource.



Evaluation

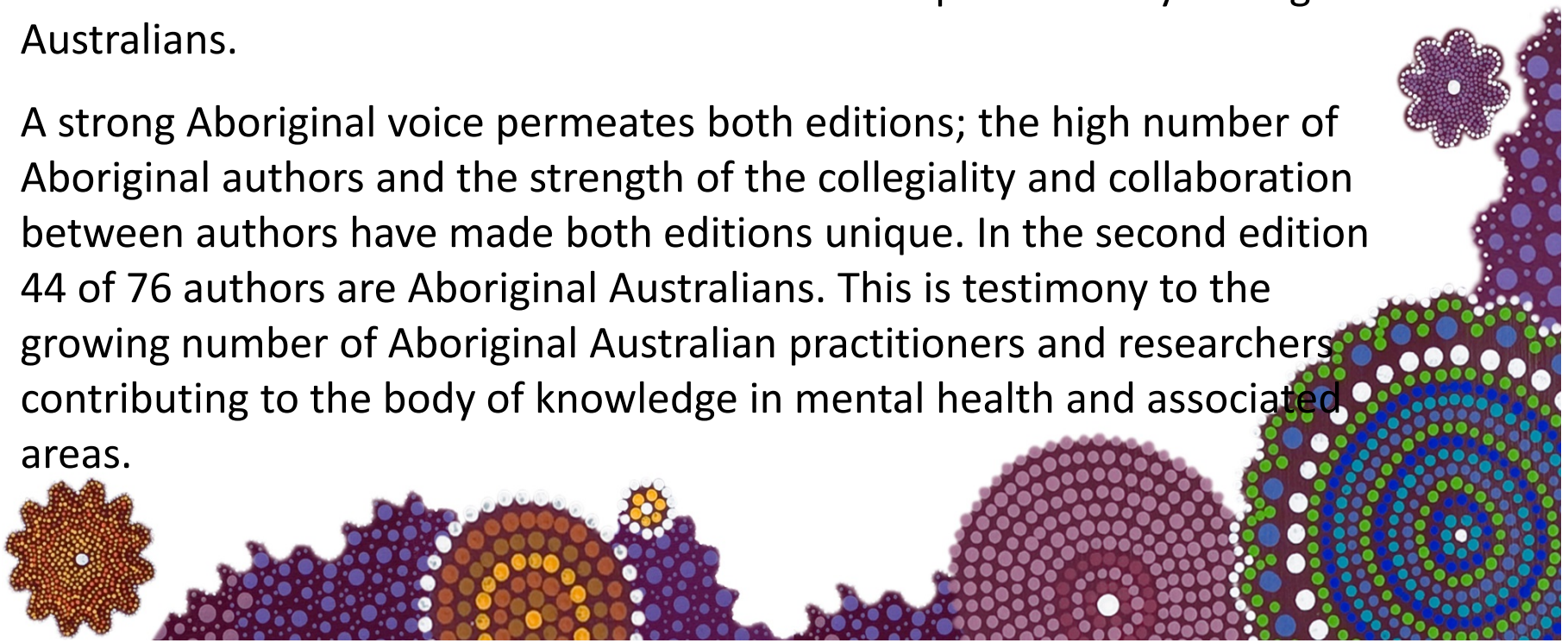
- A comprehensive evaluation regarding the quality, readability and usefulness of the *'Working Together'* book and a post-test with Cultural Competence workshop participants confirmed positive changes in their understanding and practice after using the resource (Walker 2011).
- The high demand for the book was filling a gap in the knowledge base and resources for health and mental health practitioners and academics delivering courses to future mental health practitioners.
- It is a core text for many courses and required reading for all psychology and social work registrations.
- It highlighted a range of gaps in the areas of mental health and disability, FASD, incarceration, the role of carers and interdisciplinary practice.



Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (1st & 2nd eds)

Written by recognised experts, practitioners and researchers in a range of disciplines within the mental health field presenting a variety of perspectives related to the causes and possible solutions to many of the social and emotional and mental health issues experienced by Aboriginal Australians.

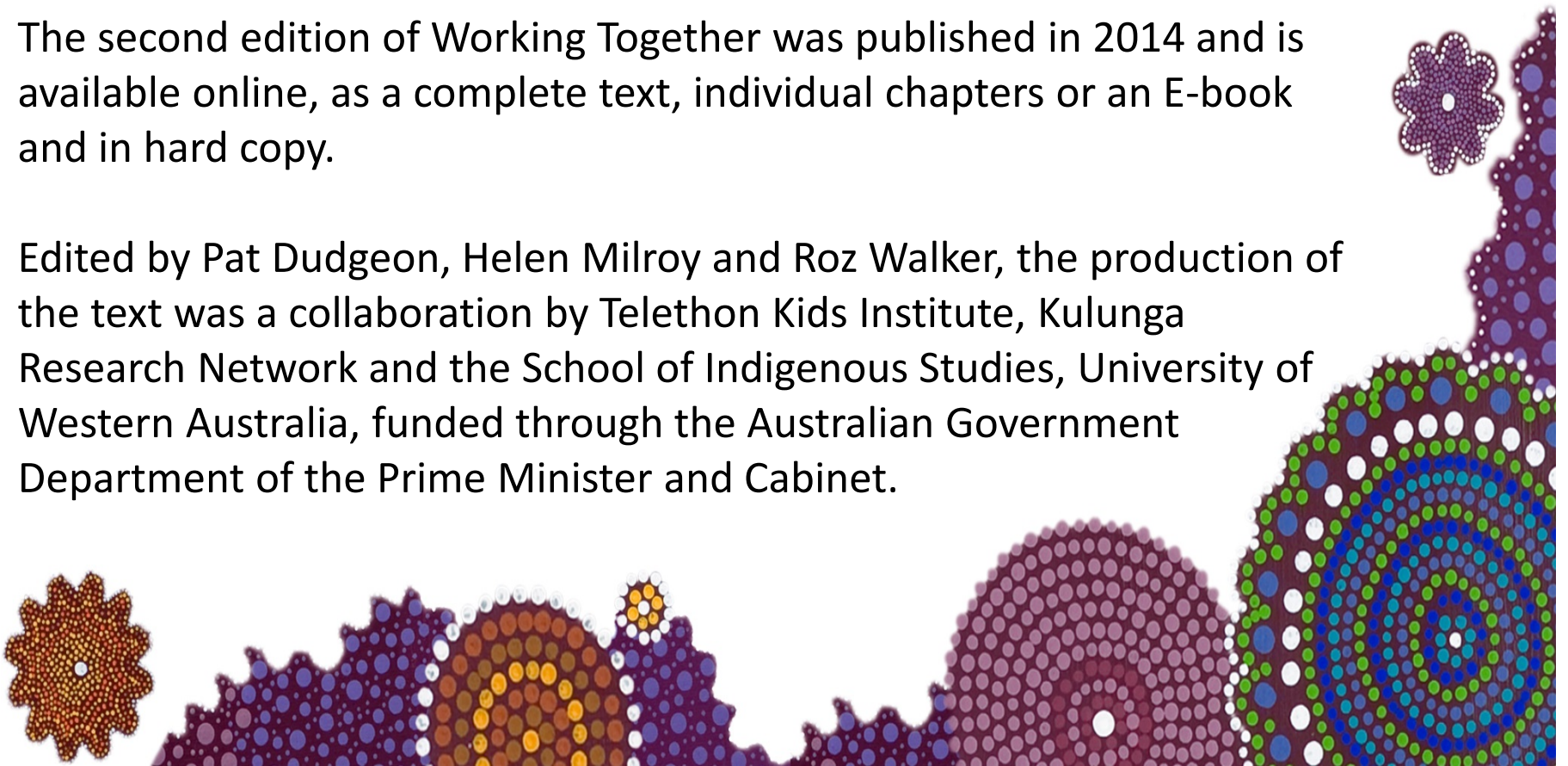
A strong Aboriginal voice permeates both editions; the high number of Aboriginal authors and the strength of the collegiality and collaboration between authors have made both editions unique. In the second edition 44 of 76 authors are Aboriginal Australians. This is testimony to the growing number of Aboriginal Australian practitioners and researchers contributing to the body of knowledge in mental health and associated areas.



Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice - 2nd Ed

The second edition of Working Together was published in 2014 and is available online, as a complete text, individual chapters or an E-book and in hard copy.

Edited by Pat Dudgeon, Helen Milroy and Roz Walker, the production of the text was a collaboration by Telethon Kids Institute, Kulunga Research Network and the School of Indigenous Studies, University of Western Australia, funded through the Australian Government Department of the Prime Minister and Cabinet.

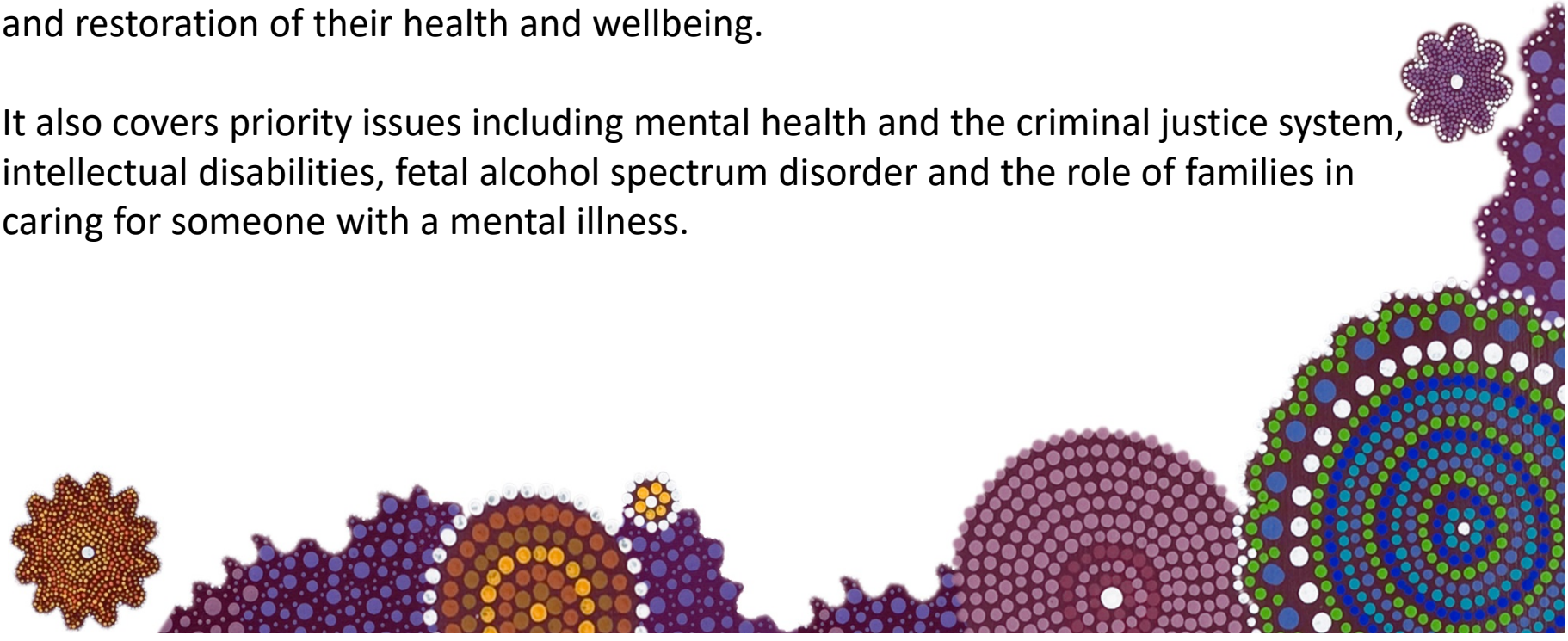


Working Together - 2nd Edition

This edition builds on the first by providing important revisions to many of the chapters to update statistics, and policy and practice, workforce development changes, capacity building, and evidence based research.

It also includes **ten new contributions with a strong focus on healing models and programs** that reflects their significance to Aboriginal people and to the maintenance and restoration of their health and wellbeing.

It also covers priority issues including mental health and the criminal justice system, intellectual disabilities, fetal alcohol spectrum disorder and the role of families in caring for someone with a mental illness.

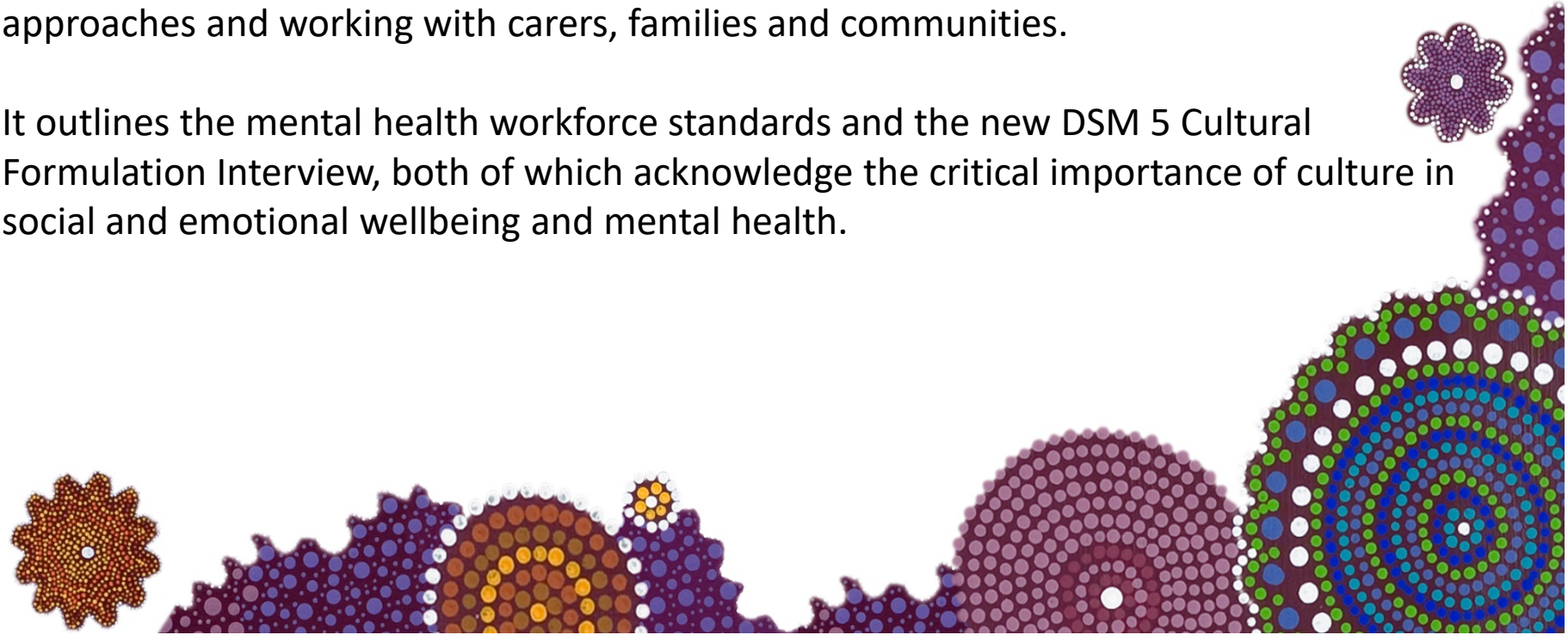


Working Together- 2nd Edition

The new edition examines issues across the life course, with a greater focus on children and young people; the significant impacts of mental health in the justice system; the cultural determinants of social and emotional wellbeing; and intellectual and development disabilities.

It includes holistic models of care, as well as interdisciplinary and inter-professional approaches and working with carers, families and communities.

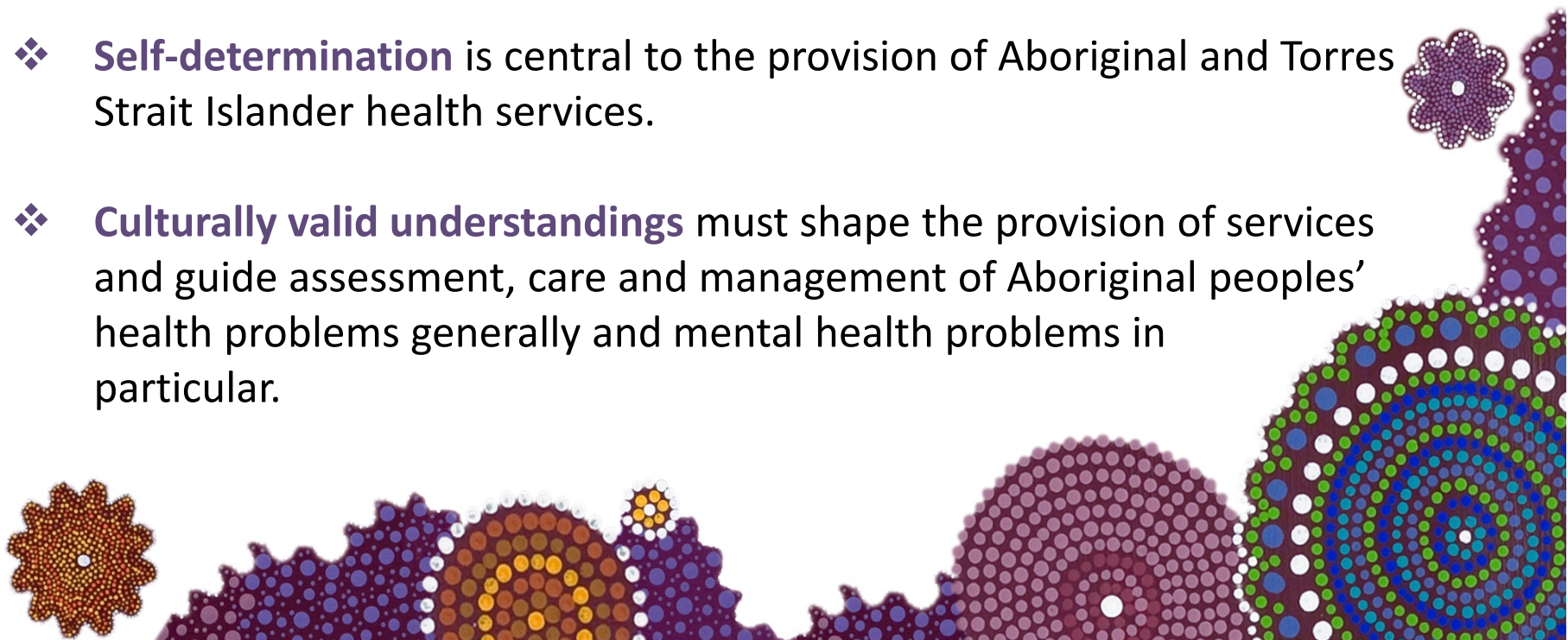
It outlines the mental health workforce standards and the new DSM 5 Cultural Formulation Interview, both of which acknowledge the critical importance of culture in social and emotional wellbeing and mental health.



Principles and Practice

The development of *Working Together* is underpinned by the Mental Health and Social and Emotional Wellbeing 2004–2009 **nine guiding principles**:

- Health is viewed in a **holistic context** that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing.
- **Self-determination** is central to the provision of Aboriginal and Torres Strait Islander health services.
- **Culturally valid understandings** must shape the provision of services and guide assessment, care and management of Aboriginal peoples' health problems generally and mental health problems in particular.



- The experiences of **trauma and loss** since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.

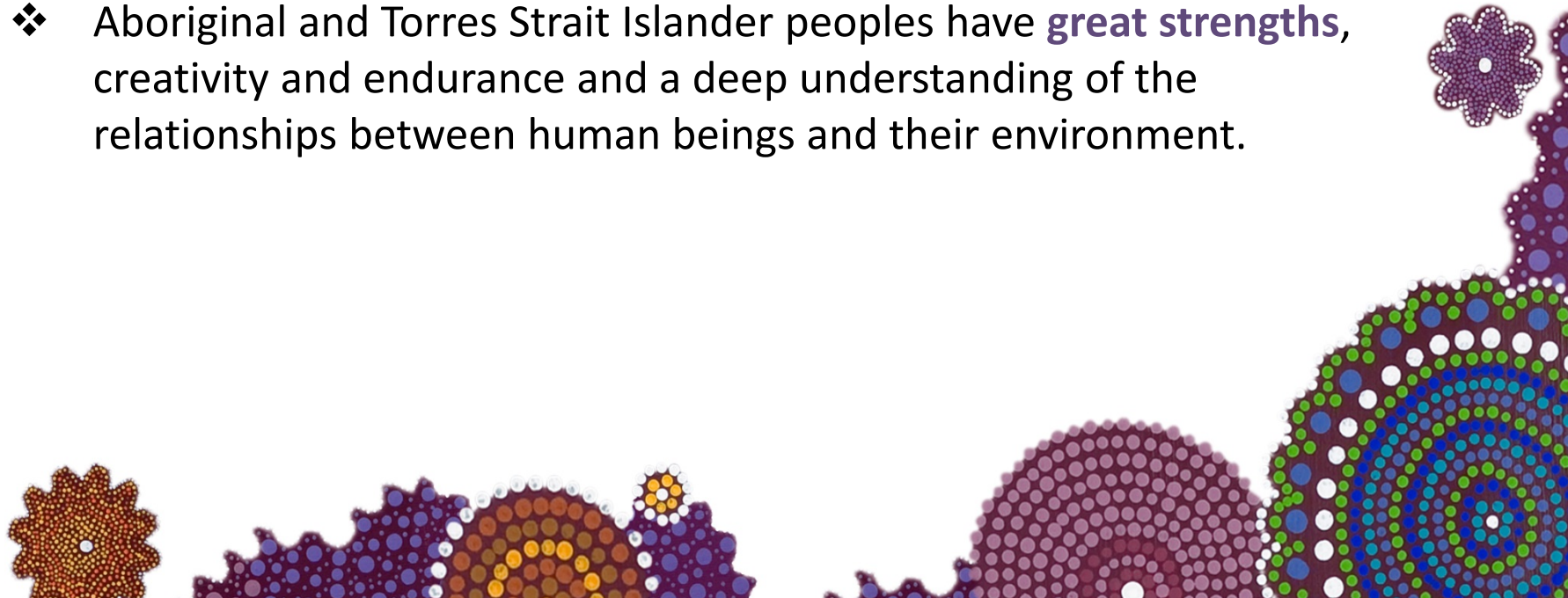
- The **human rights** of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health (as against mental ill health). Human rights relevant to mental illness must be specifically addressed.

- **Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors** and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.

- **The centrality** of Aboriginal and Torres Strait Islander **family and kinship** as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

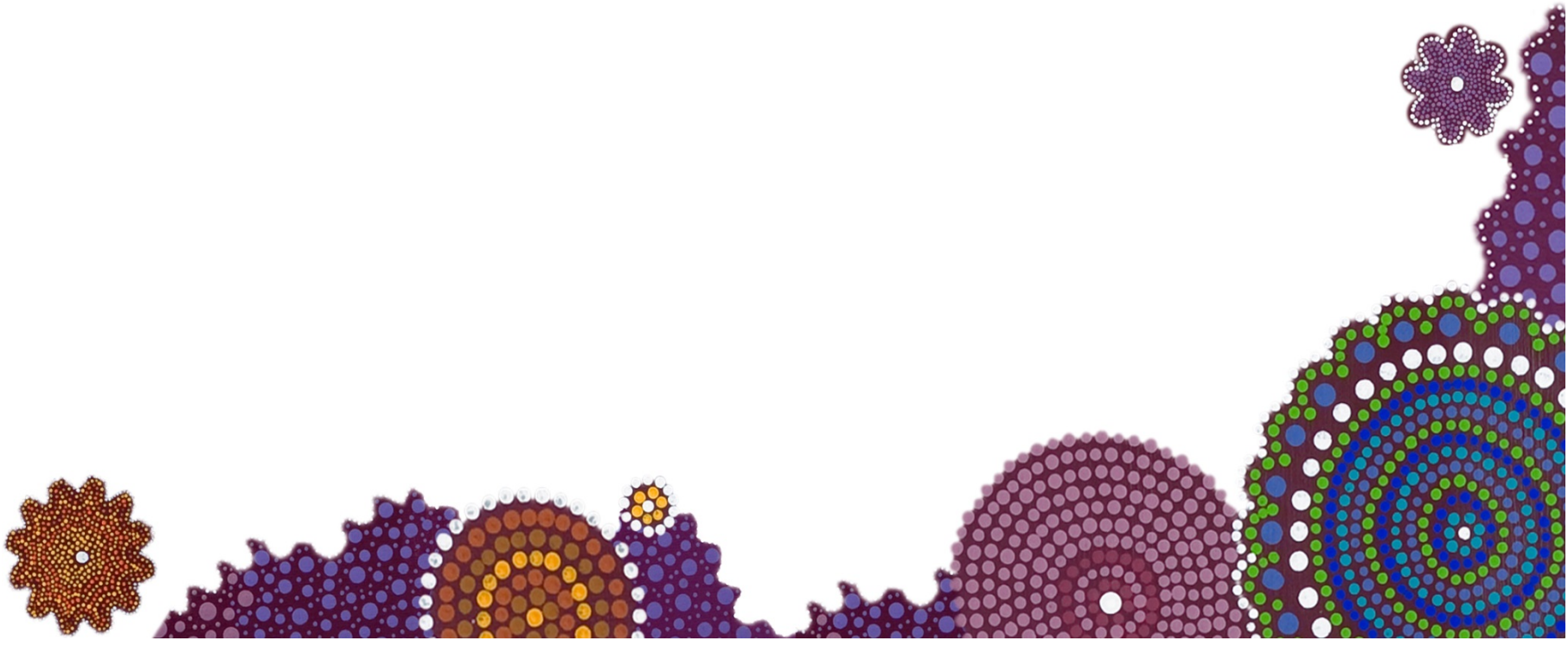
- The **diversity** of Aboriginal or Torres Strait Islander **culture** or group, but numerous groupings, languages, kinships and tribes, as well as different ways of living in urban, rural or remote settings

- Aboriginal and Torres Strait Islander peoples have **great strengths**, creativity and endurance and a deep understanding of the relationships between human beings and their environment.



The Book Structure

The book is structured into six parts the following section briefly details that content and purpose of each of these sections.

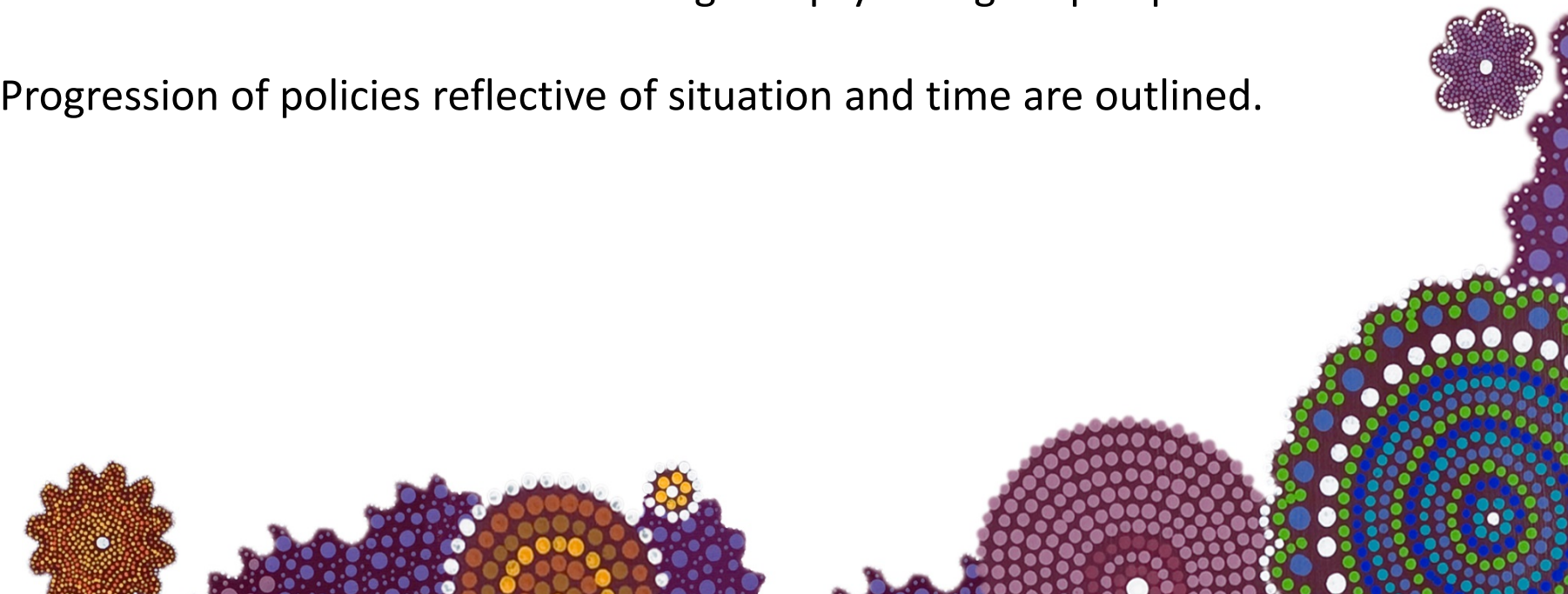


Part One: History and Contexts

Provides an overview from a historical, social, emotional and cultural context, within a mental health framework.

Impacts of colonisation and cultural devastation in contrast to resistance, resilience, equality, empowerment and cultural recognition are discussed from a social and emotional wellbeing and psychological perspective.

Progression of policies reflective of situation and time are outlined.



Part Two: Issues and Influences

This section describes various issues and influences on people's mental health and social and emotional wellbeing, including a clinical description and diagnosis of mental health.

Substance misuse, suicide and the over-representation of people in the criminal justice system are viewed as most significantly impacting on individuals and communities.

Part Three: Standards, Principles and Practice

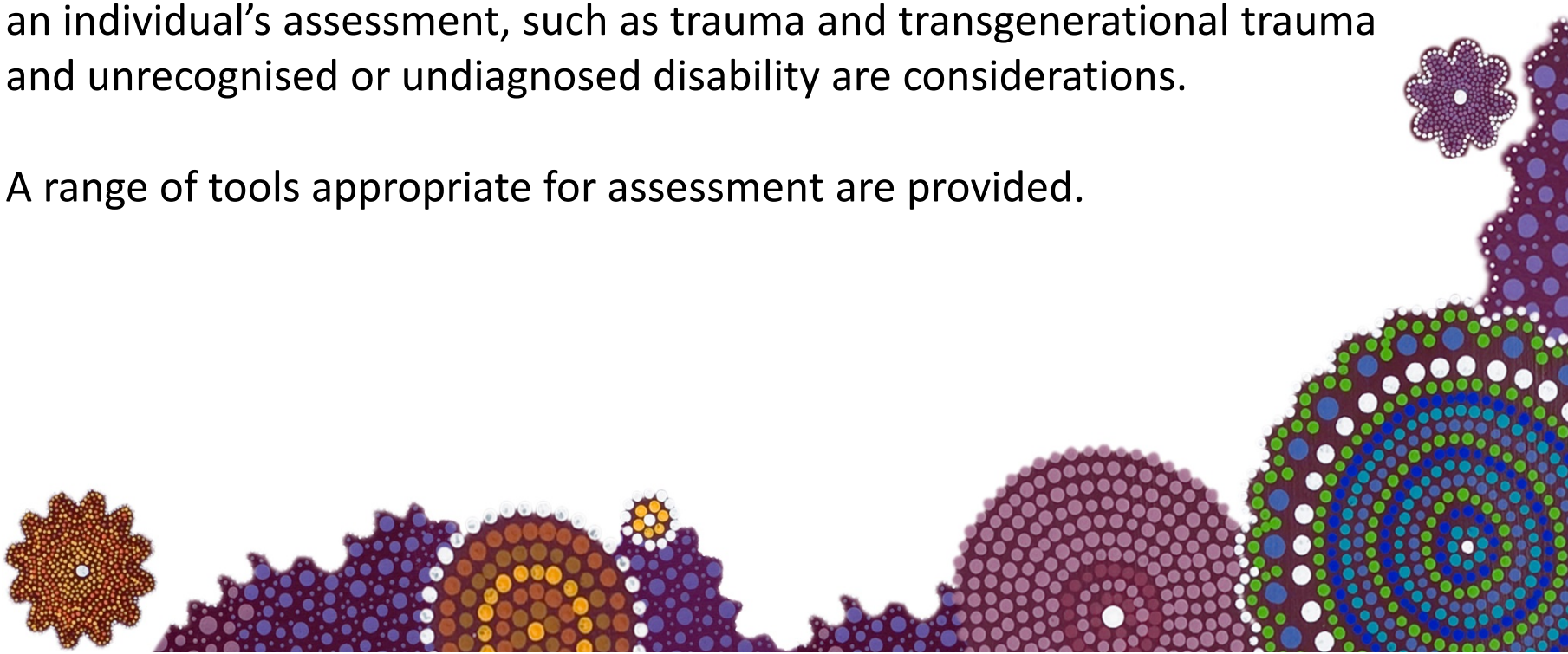
Better health outcomes can be achieved by best work practice, which includes consideration of and working to the National Practice Standards and ensuring, where possible, support is offered within an interdisciplinary team in a culturally competent and culturally secure environment.

Part Four: Assessment and Management

Assessing and managing an individual and ensuring cultural competency and a culturally secure environment are highlighted.

Acknowledging and understanding the diversity of attributes impacting on an individual's assessment, such as trauma and transgenerational trauma and unrecognised or undiagnosed disability are considerations.

A range of tools appropriate for assessment are provided.

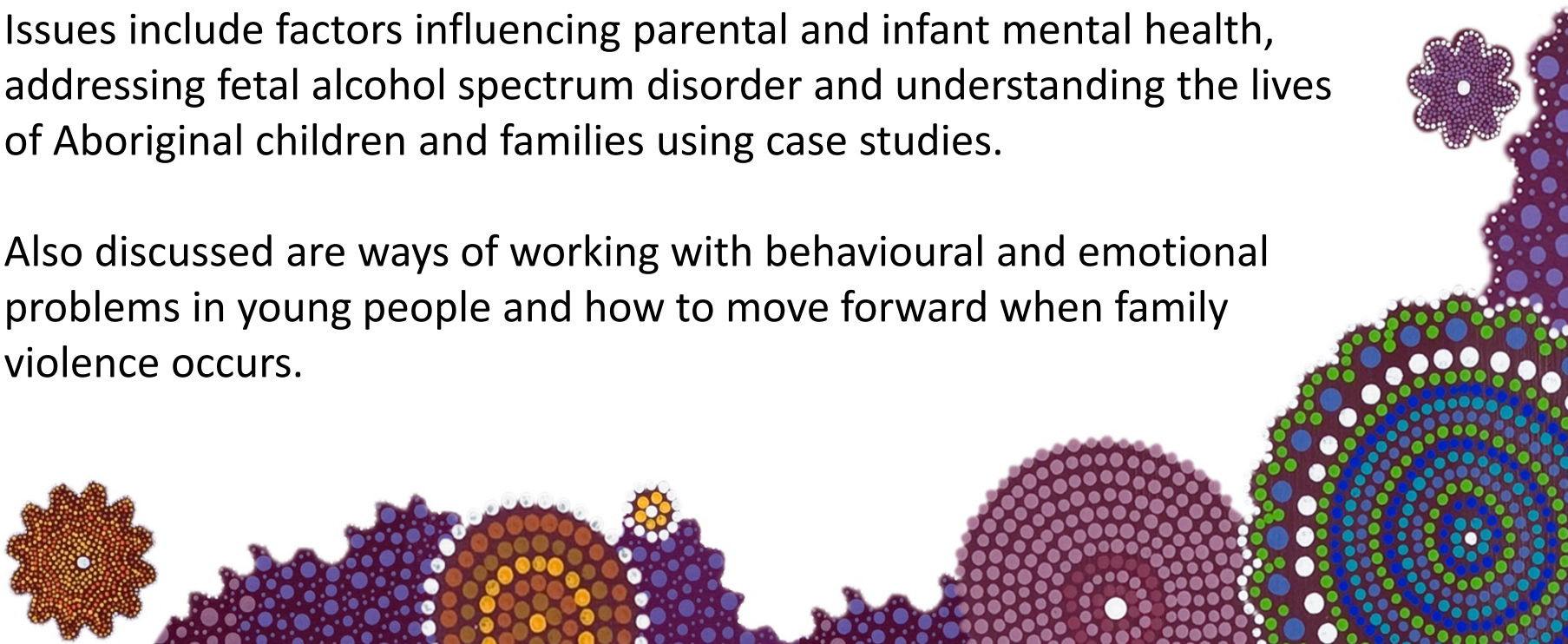


Part Five: Working with Children, Families and Communities

This section focuses on the complex issues surrounding young Aboriginal people and explores ways for families and communities to deal with them.

Issues include factors influencing parental and infant mental health, addressing fetal alcohol spectrum disorder and understanding the lives of Aboriginal children and families using case studies.

Also discussed are ways of working with behavioural and emotional problems in young people and how to move forward when family violence occurs.

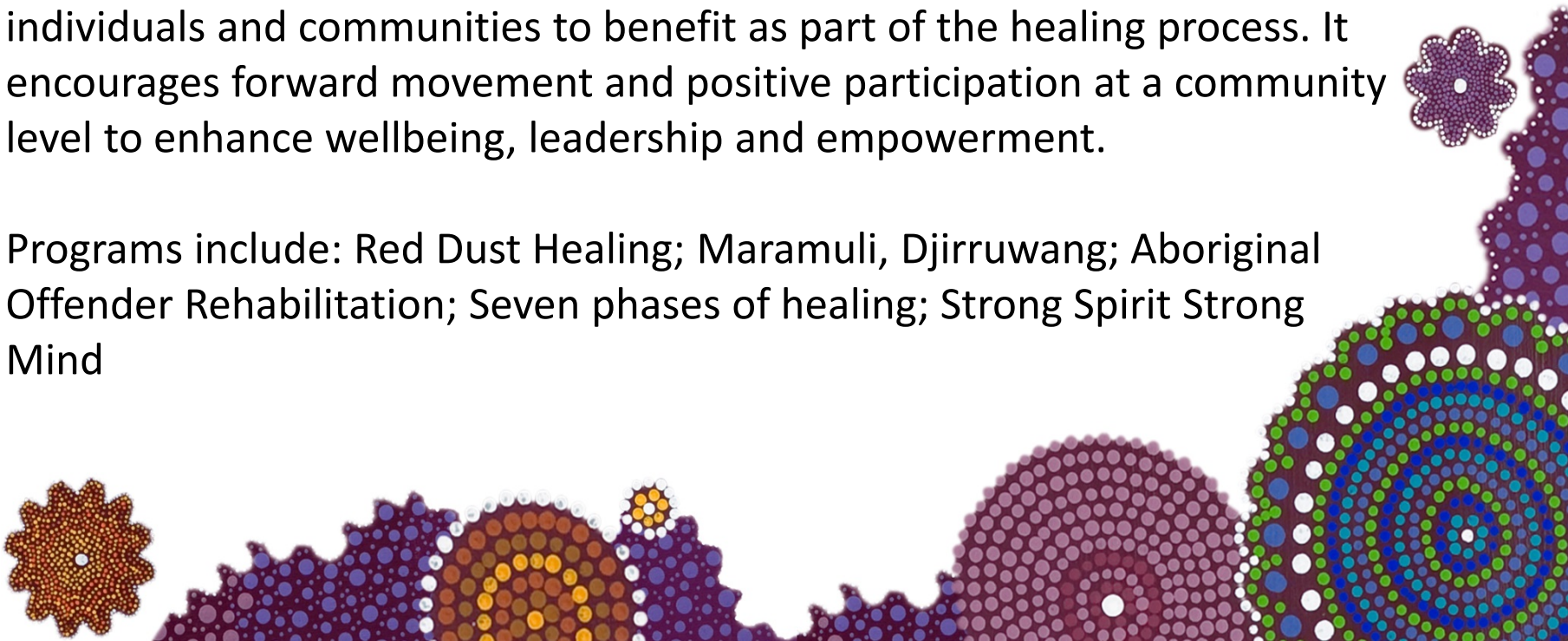


Part Six: Aboriginal Healing Models and Programs

A number of culturally sensitive, culturally driven, culturally developed and culturally implemented programs and models provide pathways forward for individuals and communities.

Involvement in these culturally specific models and programs will enable individuals and communities to benefit as part of the healing process. It encourages forward movement and positive participation at a community level to enhance wellbeing, leadership and empowerment.

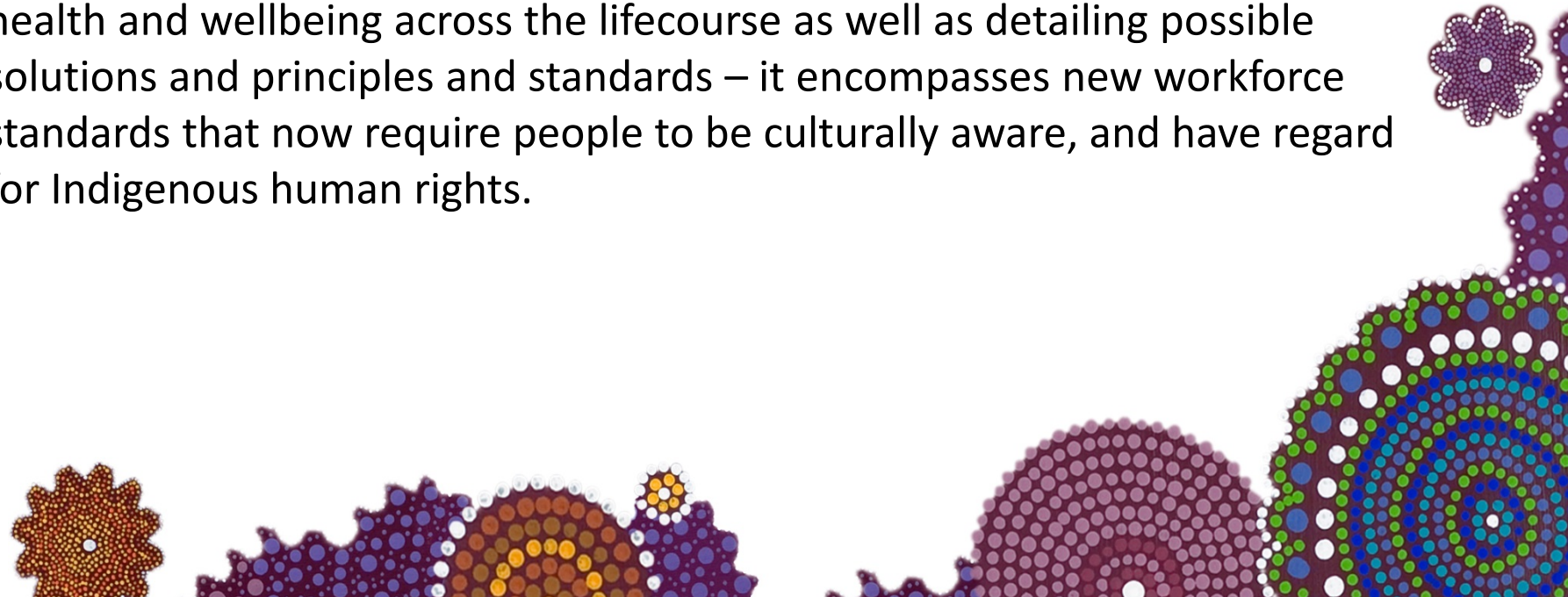
Programs include: Red Dust Healing; Maramuli, Djirruwang; Aboriginal Offender Rehabilitation; Seven phases of healing; Strong Spirit Strong Mind



Content

Leading Edge, Radical Transformative; Empowering, Evidence based, Well researched, Peer reviewed

The content highlights the serious extent of crisis in Aboriginal mental health and wellbeing across the lifecourse as well as detailing possible solutions and principles and standards – it encompasses new workforce standards that now require people to be culturally aware, and have regard for Indigenous human rights.

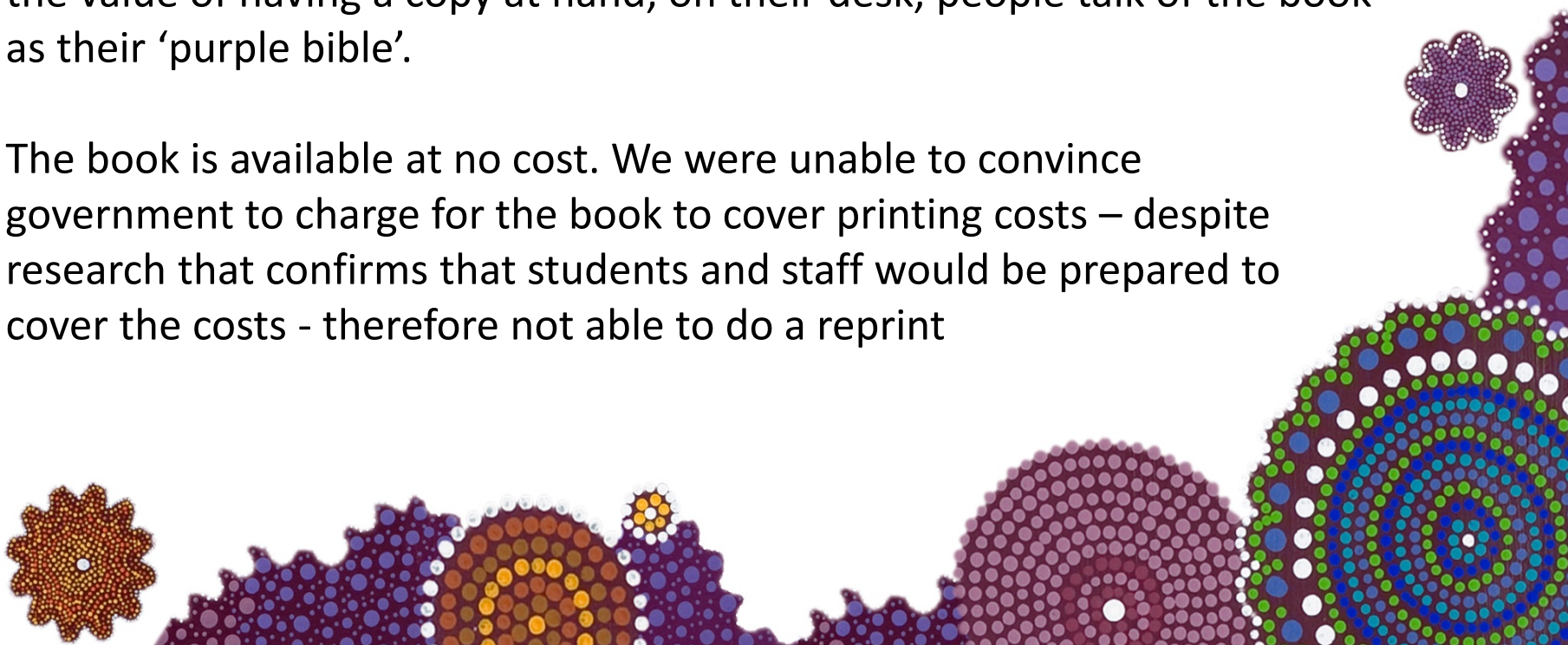


Where are we at?

Over 38,000 hardcopies disseminated. Over 50,000 online copies accessed, individual chapters downloaded, an e-book is available and evaluated as highly suitable for students and health professionals.

Hundreds of people have contacted us requesting a hard copy, talking of the value of having a copy at hand, on their desk, people talk of the book as their ‘purple bible’.

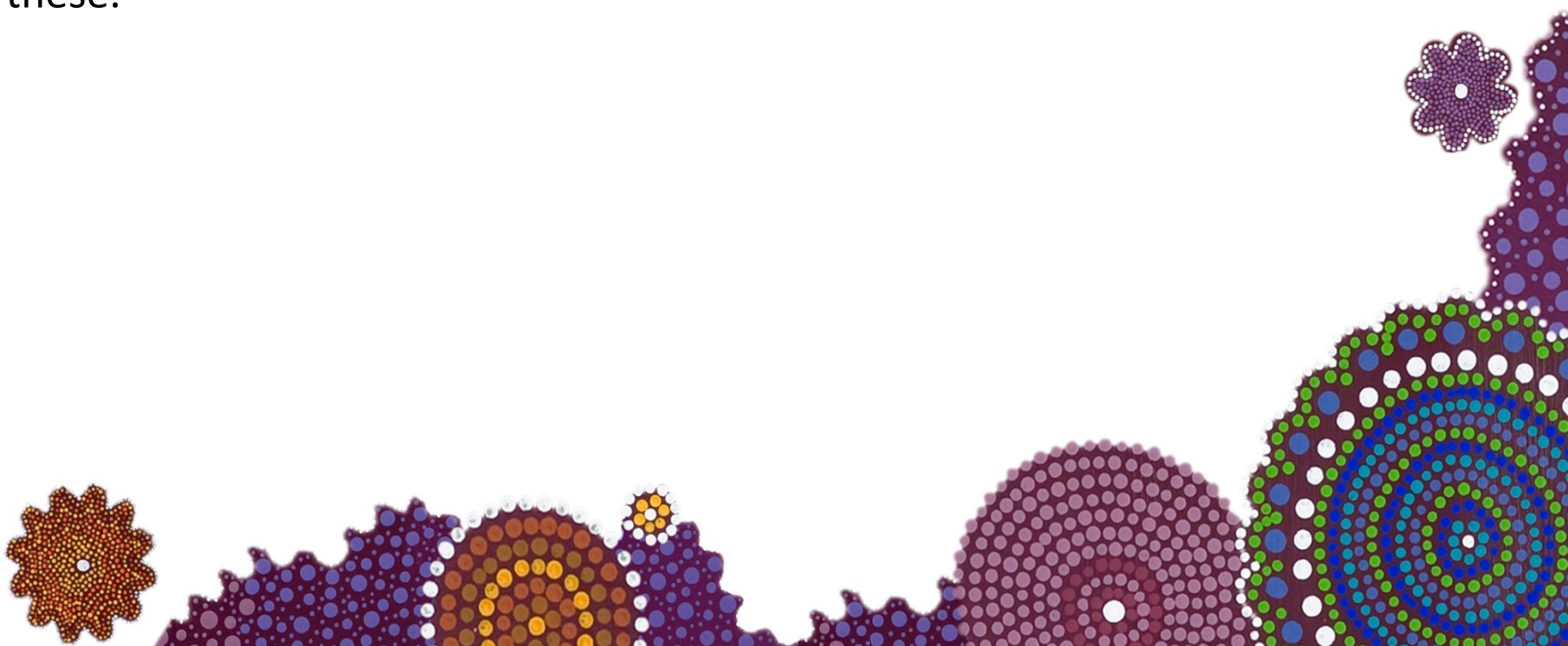
The book is available at no cost. We were unable to convince government to charge for the book to cover printing costs – despite research that confirms that students and staff would be prepared to cover the costs - therefore not able to do a reprint



Where are we at?

In terms of today, it was suggested that it might be useful to talk through some case studies to illustrate how these guiding principles apply in the real world.

There are several in the book, and I have selected a few to illustrate these.



Recapping the 9 principles

1. The Aboriginal concept of health is holistic.
2. Self-determination is central to the provision of Aboriginal health services.
3. Culturally valid understanding must shape provision of Aboriginal health (and mental health) care.
4. The experience of trauma and loss contribute to the impairment of Aboriginal culture and mental health wellbeing.
5. The human rights of Aboriginal people must be recognised and enforced.
6. Racism, stigma, adversity and social disadvantage must be addressed in strategies aimed at improving Aboriginal mental health.
7. The strength and centrality of Aboriginal family and kinship must be understood and accepted.
8. The concept of a diversity in culture and/or groups.
9. Aboriginal people have great strengths including creativity, endurance, humour, compassion and spirituality

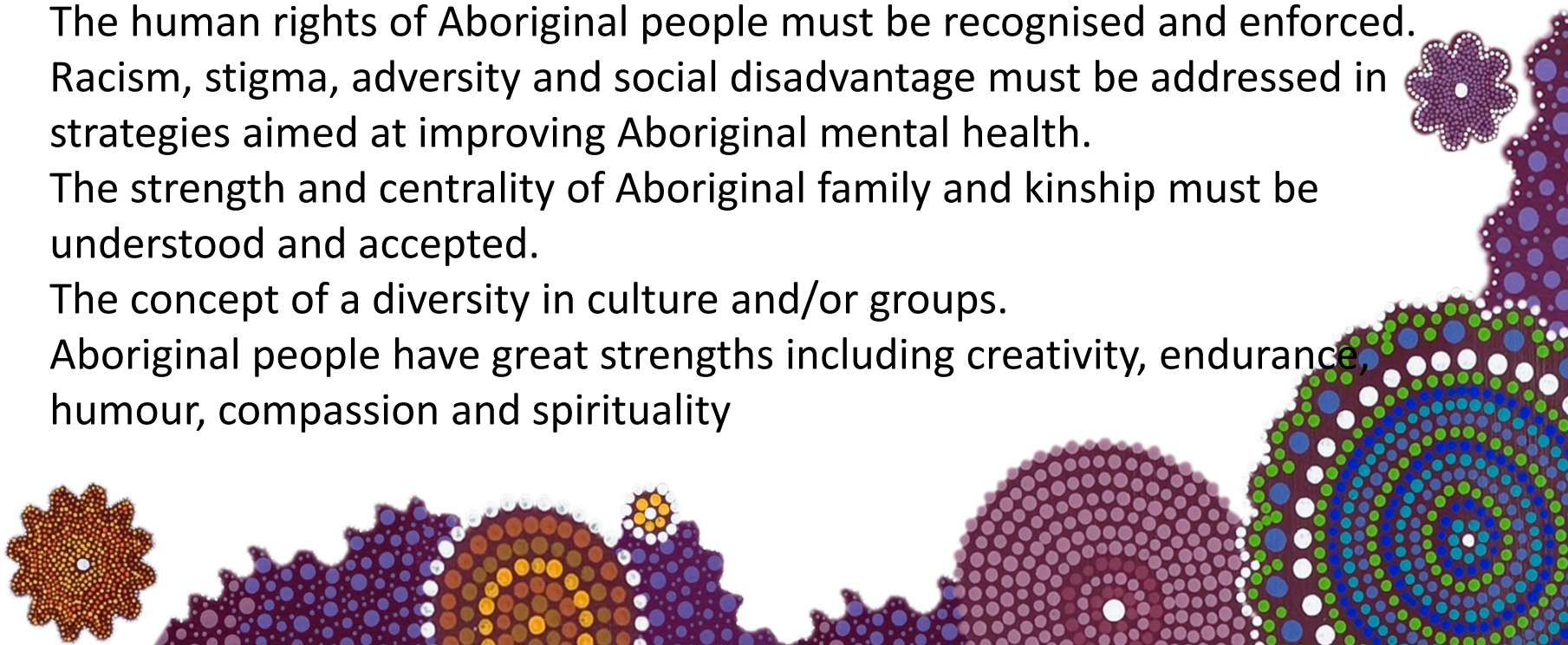


Figure 4.1: Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' Perspective

*This conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.

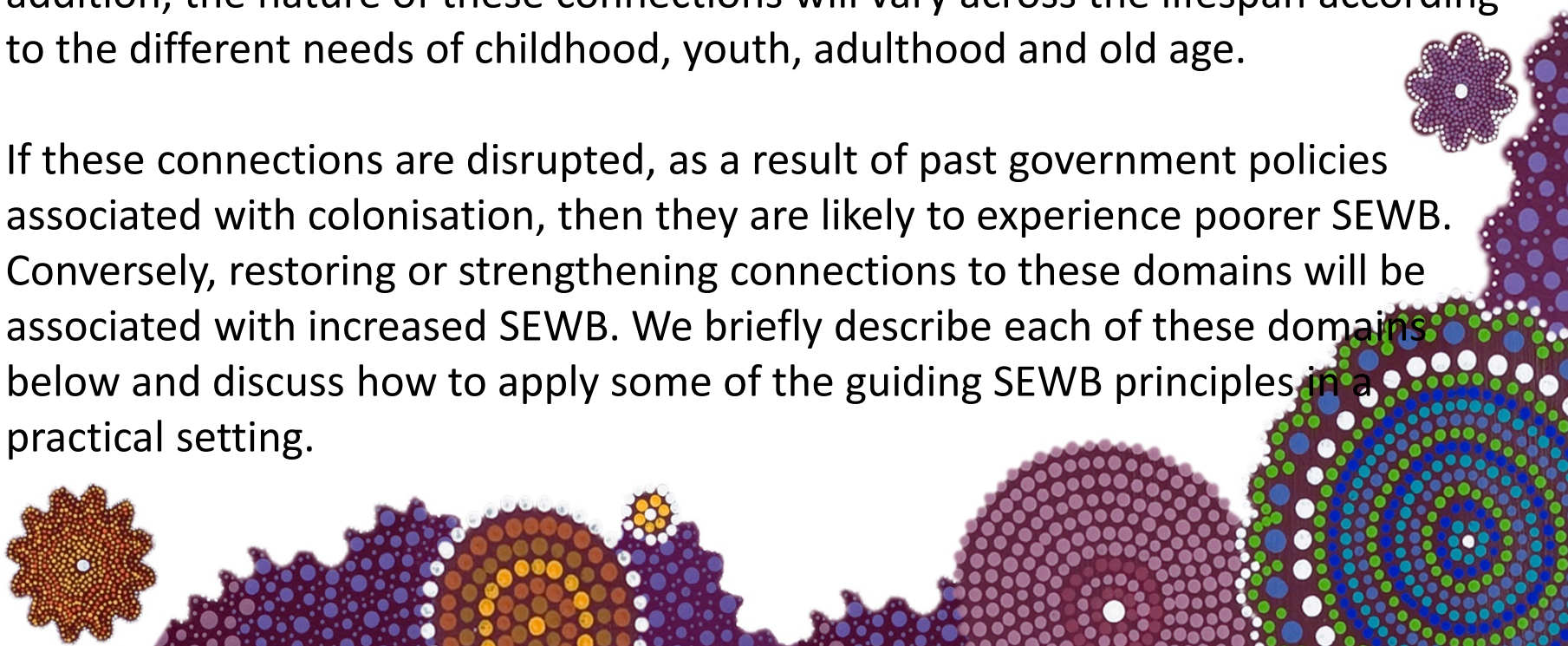
Artist: Tristan Schultz, RelativeCreative.

Social and Emotional Wellbeing

The diagram shows that the SEWB of individuals, families and communities are shaped by connections to body, mind and emotions, family and kinship, community, culture, land and spirituality.

People may experience healthy connections and a sense of resilience in some domains, while experiencing difficulty and/or the need for healing in others. In addition, the nature of these connections will vary across the lifespan according to the different needs of childhood, youth, adulthood and old age.

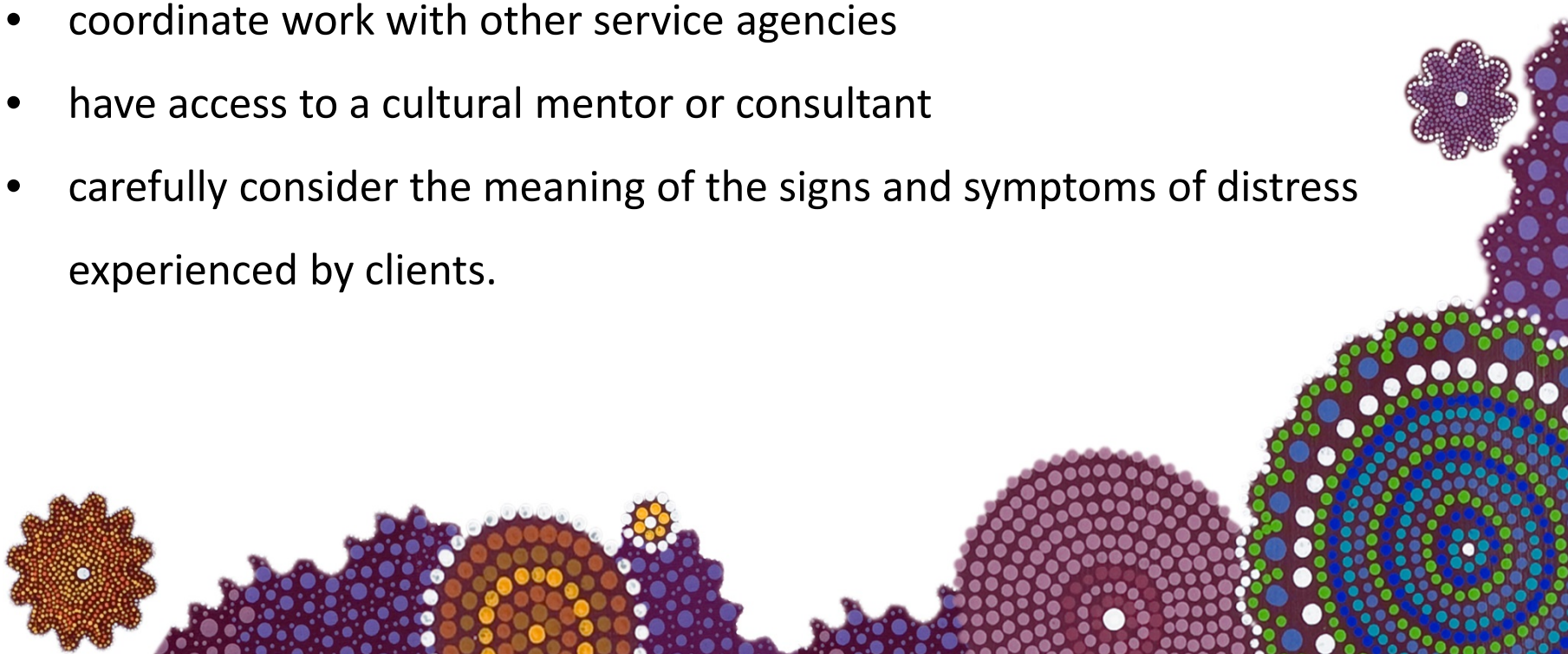
If these connections are disrupted, as a result of past government policies associated with colonisation, then they are likely to experience poorer SEWB. Conversely, restoring or strengthening connections to these domains will be associated with increased SEWB. We briefly describe each of these domains below and discuss how to apply some of the guiding SEWB principles in a practical setting.



Social and Emotional Wellbeing

In relation to working with mental health and SEWB, general recommendations in the literature include the need to:

- collaborate and build relationships within community
- have prior knowledge of appropriate referral pathways
- coordinate work with other service agencies
- have access to a cultural mentor or consultant
- carefully consider the meaning of the signs and symptoms of distress experienced by clients.

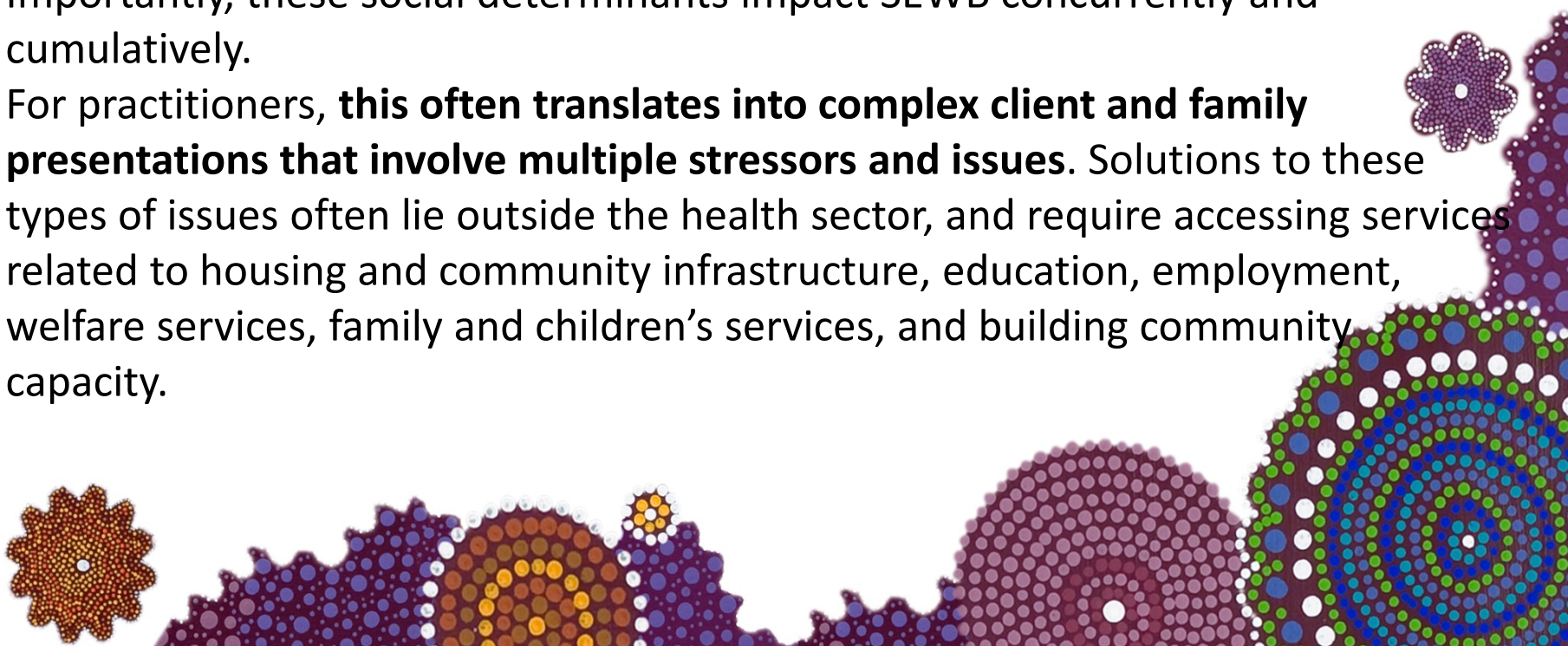


Social Determinants

It is also important to consider SEWB connections within broader social, cultural, political and historical contexts. The social determinants of mental health and SEWB for Aboriginal people include socioeconomic status, the impact of: poverty, unemployment, housing, educational attainment, racial discrimination, exposure to violence, trauma and stressful life events, and access to community resources.

Importantly, these social determinants impact SEWB concurrently and cumulatively.

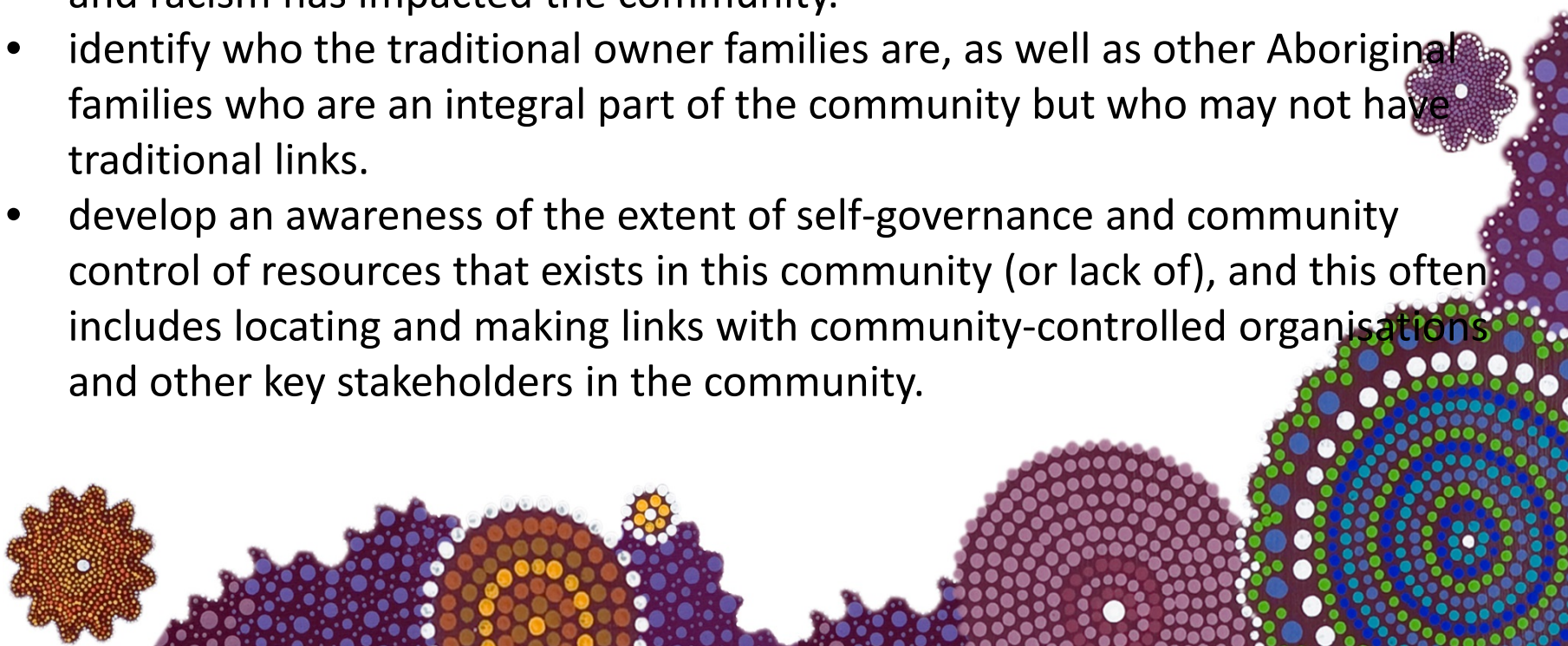
For practitioners, **this often translates into complex client and family presentations that involve multiple stressors and issues**. Solutions to these types of issues often lie outside the health sector, and require accessing services related to housing and community infrastructure, education, employment, welfare services, family and children's services, and building community capacity.



Strategies for Practitioners

To be effective, practitioners need to:

- develop awareness and engage practically with historical, political and cultural determinants
- develop a basic knowledge of the history of the traditional owner groups in the community they work in, and think about the ways in which colonisation and racism has impacted the community.
- identify who the traditional owner families are, as well as other Aboriginal families who are an integral part of the community but who may not have traditional links.
- develop an awareness of the extent of self-governance and community control of resources that exists in this community (or lack of), and this often includes locating and making links with community-controlled organisations and other key stakeholders in the community.

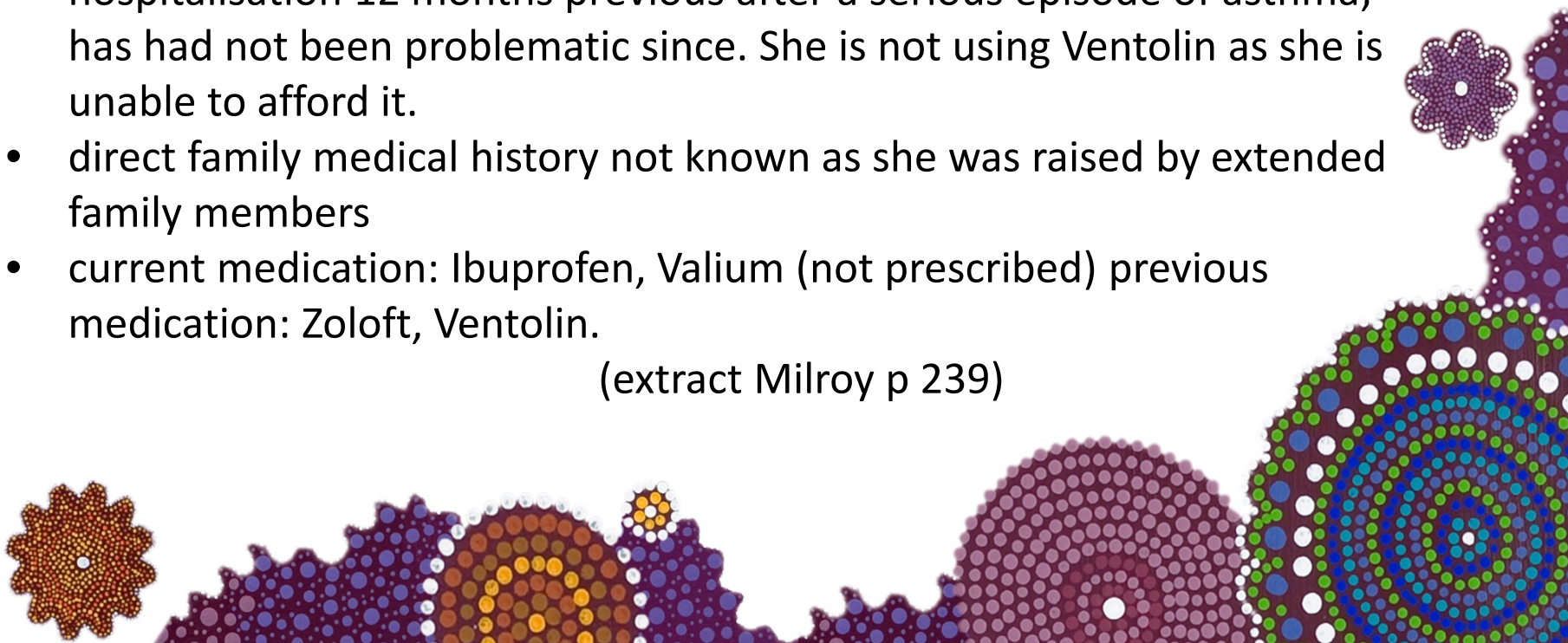


Case Study: Jacinta

A 32 year-old Aboriginal woman (Jacinta) presents to her GP with the following symptoms:

- low mood, low self-esteem, frequent fatigue, loss of energy, moodiness, rapid weight loss, periods of uncontrolled crying, shortness of breath, nervousness, re-occurring migraines, broken sleep
- recently started smoking again after five years
- hospitalisation 12 months previous after a serious episode of asthma; has had not been problematic since. She is not using Ventolin as she is unable to afford it.
- direct family medical history not known as she was raised by extended family members
- current medication: Ibuprofen, Valium (not prescribed) previous medication: Zoloft, Ventolin.

(extract Milroy p 239)



- Jacinta has six children under seven in her care and biological mother of two. Her sister who is the mother of the other four children has had to leave town to care for a sick extended family member in a remote area. The children remained in town as travel costs were too high. It is not known how long she will be away.
- Jacinta had to resign from her employment to care for the children and does not receive any extra money from Centrelink to look after the children. Her sister is unable to contribute as she is supporting the extended family member's medical treatment.
- Jacinta is struggling to pay her rent and frequently misses meals to provide food for the children. She has lost considerable weight and tells the GP that caring for the children is causing her to have memories of her own childhood.
- She reports feeling disconnected from community and not belonging, as she has only lived in the area for a few years. She is experiencing great 'shame' in having to seek assistance from her GP and is concerned about further referrals.

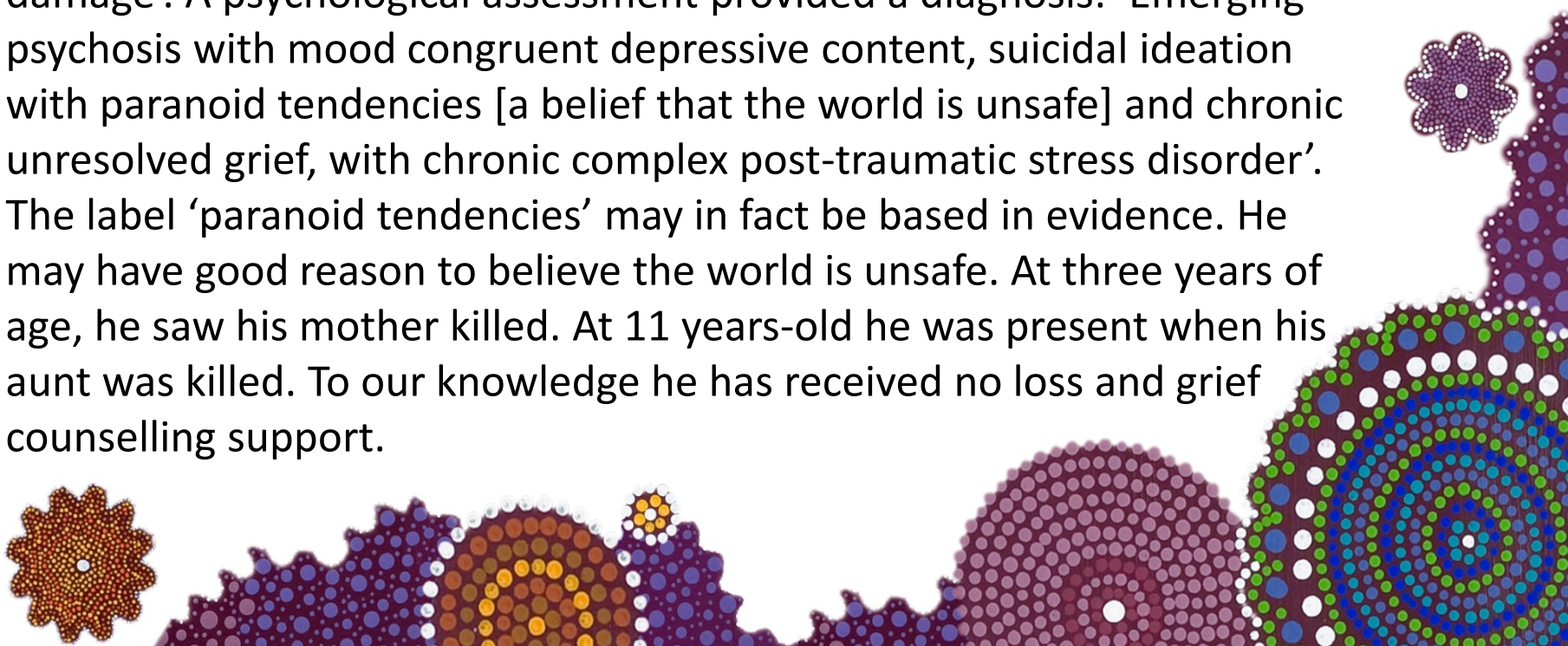
Case Study: Jacinta

Taking into account the SEWB framework and the mental health best practice guidelines consider the following issues for Jacinta's situation:

- What needs to be done and who should be involved in developing a care plan for her?
- As a member of the interdisciplinary team, describe your role and what you can bring to the team?
- What challenges and opportunities do you think may exist for you in the team? What considerations need to be made to ensure the success of the team in providing best practice?
- How may diagnosis, treatment and referral impact on the following levels: Individual/Family/Community?

Case Study- Mitch

A young man just entering early adolescence: ‘expresses suicidal ideation, stating he wants to hang himself; has periods of antisocial behaviour, throwing stones at the house and climbing on the roof at home or school. During a recent episode at school he substantially damaged the school buildings. There is now court pending regarding this damage’. A psychological assessment provided a diagnosis: ‘Emerging psychosis with mood congruent depressive content, suicidal ideation with paranoid tendencies [a belief that the world is unsafe] and chronic unresolved grief, with chronic complex post-traumatic stress disorder’. The label ‘paranoid tendencies’ may in fact be based in evidence. He may have good reason to believe the world is unsafe. At three years of age, he saw his mother killed. At 11 years-old he was present when his aunt was killed. To our knowledge he has received no loss and grief counselling support.



Identifying Trauma

Identifying trauma in a given population must start with behavioural observations. Through observation we can begin to consider the likelihood of trauma in an individual, family, community, or other grouping. Our capacity to listen to, and witness the human story without judgment is vital, linking what we hear and see to empirical evidence.

However, we must act in a manner that does not re-traumatise those with whom we are working. The following case study of Mitch highlights the need for further investigation, but not to label without understanding the full story.

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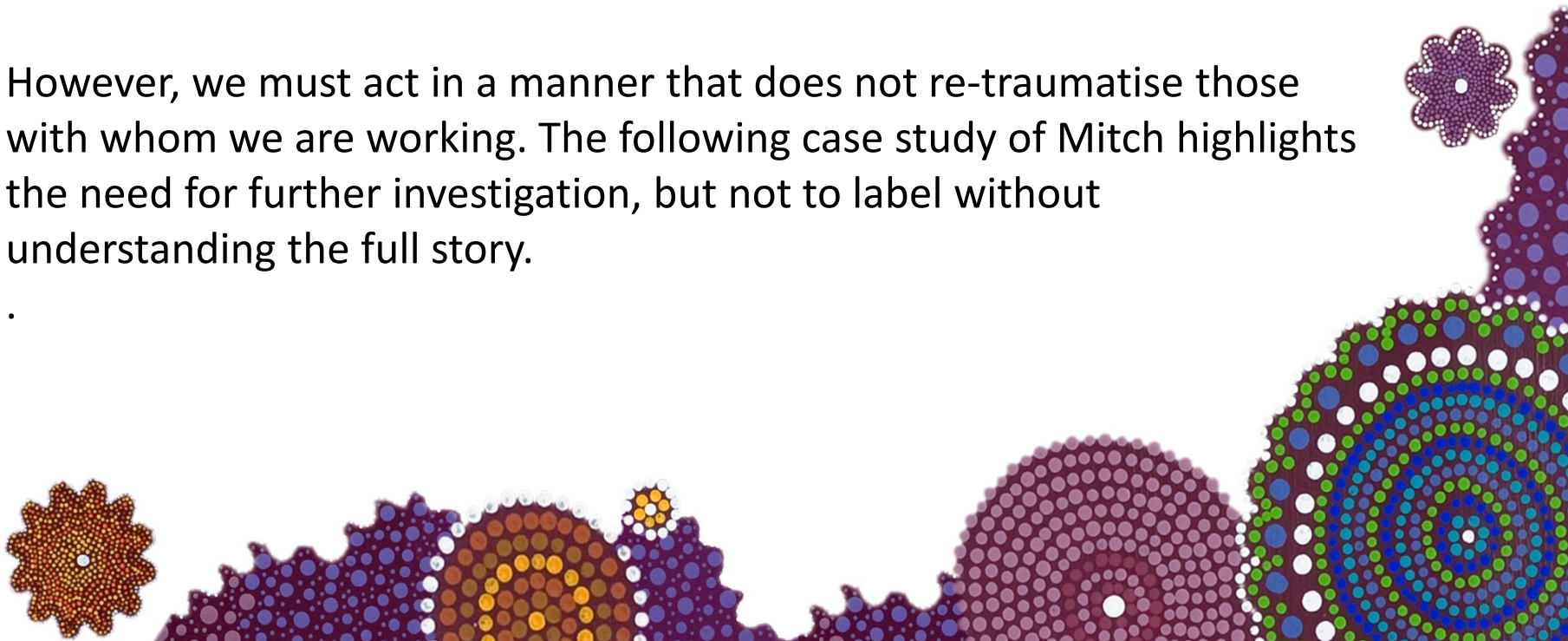
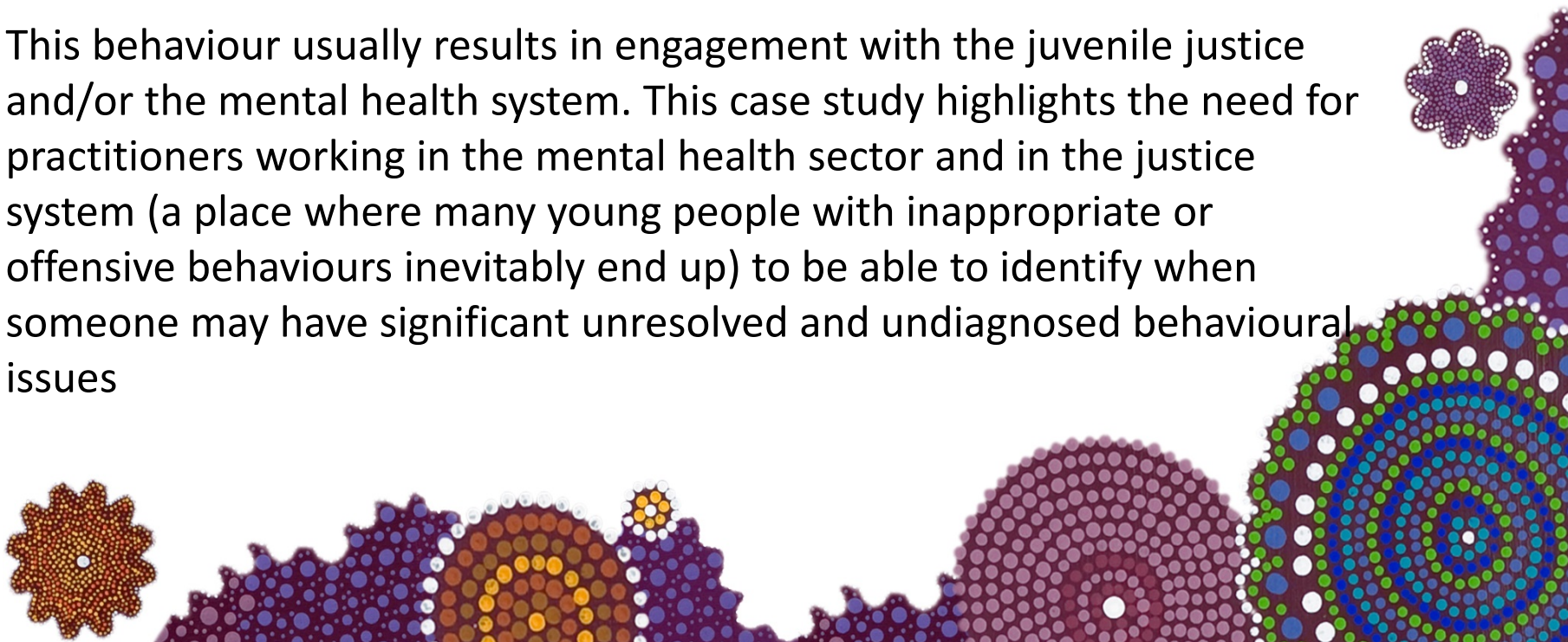


Case Study (Cont)

The increasing incarceration of Aboriginal juveniles, while a reflection on the capacity and appropriateness of the justice system, is a product of young people, described in part in the above case study, transitioning from childhood trauma experiences as victims, to perpetrators of behaviours labelled as ‘bad’ or ‘mad’.

This behaviour usually results in engagement with the juvenile justice and/or the mental health system. This case study highlights the need for practitioners working in the mental health sector and in the justice system (a place where many young people with inappropriate or offensive behaviours inevitably end up) to be able to identify when someone may have significant unresolved and undiagnosed behavioural issues

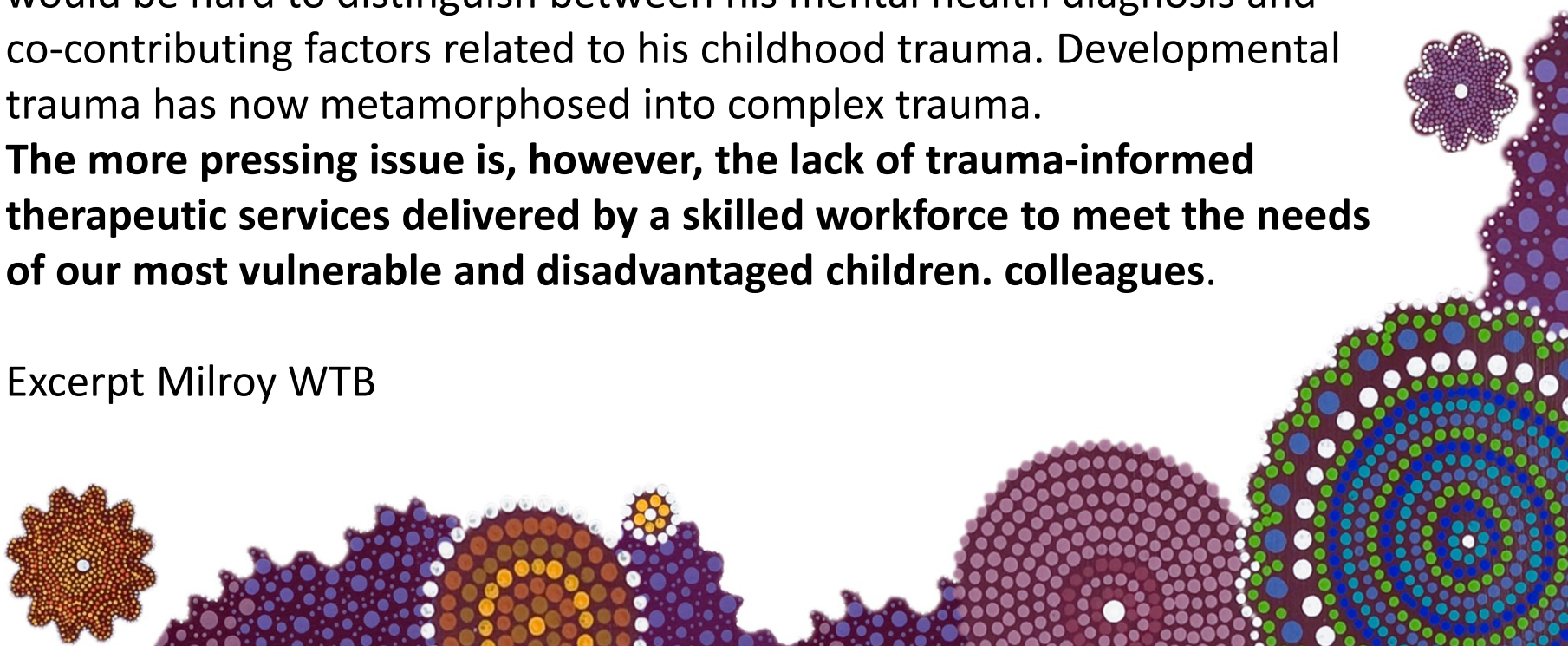


Case Study (Cont)

Such research findings have implications in our understanding of the serious situation of Aboriginal children who display distressed behaviour. In the case study above, Mitch, the 13 year-old, was unable to get assessment until he threatened suicide. Once a report was made by the school, Child and Adolescent Mental Health (CAMH) had him assessed. It would be hard to distinguish between his mental health diagnosis and co-contributing factors related to his childhood trauma. Developmental trauma has now metamorphosed into complex trauma.

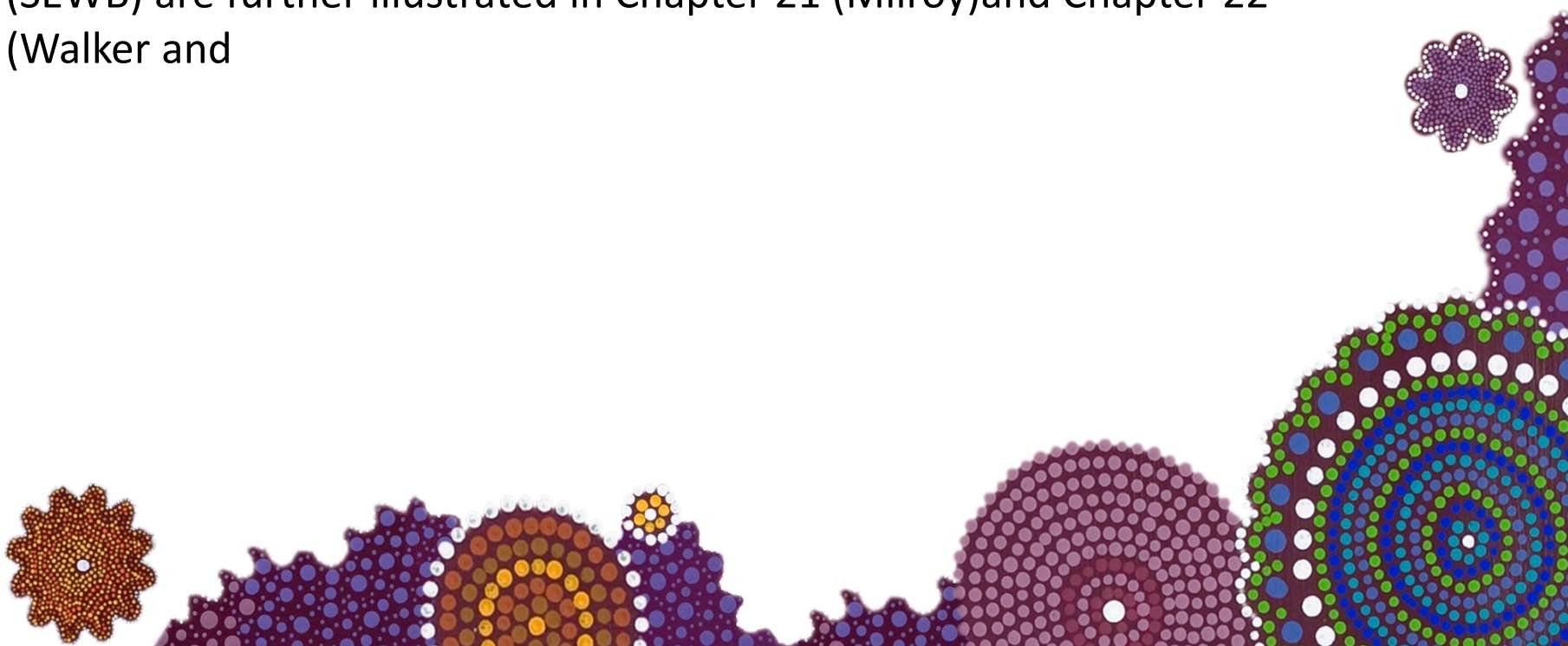
The more pressing issue is, however, the lack of trauma-informed therapeutic services delivered by a skilled workforce to meet the needs of our most vulnerable and disadvantaged children. colleagues.

Excerpt Milroy WTB



Case Studies

This would go a long way toward interrupting the passage from childhood trauma into incarceration (juvenile detention and adult prison), involuntary detention in mental health wards, or serious self-harm and/or suicide. The potentially harmful impacts across the life course related to child mental health and social and emotional wellbeing (SEWB) are further illustrated in Chapter 21 (Milroy)and Chapter 22 (Walker and



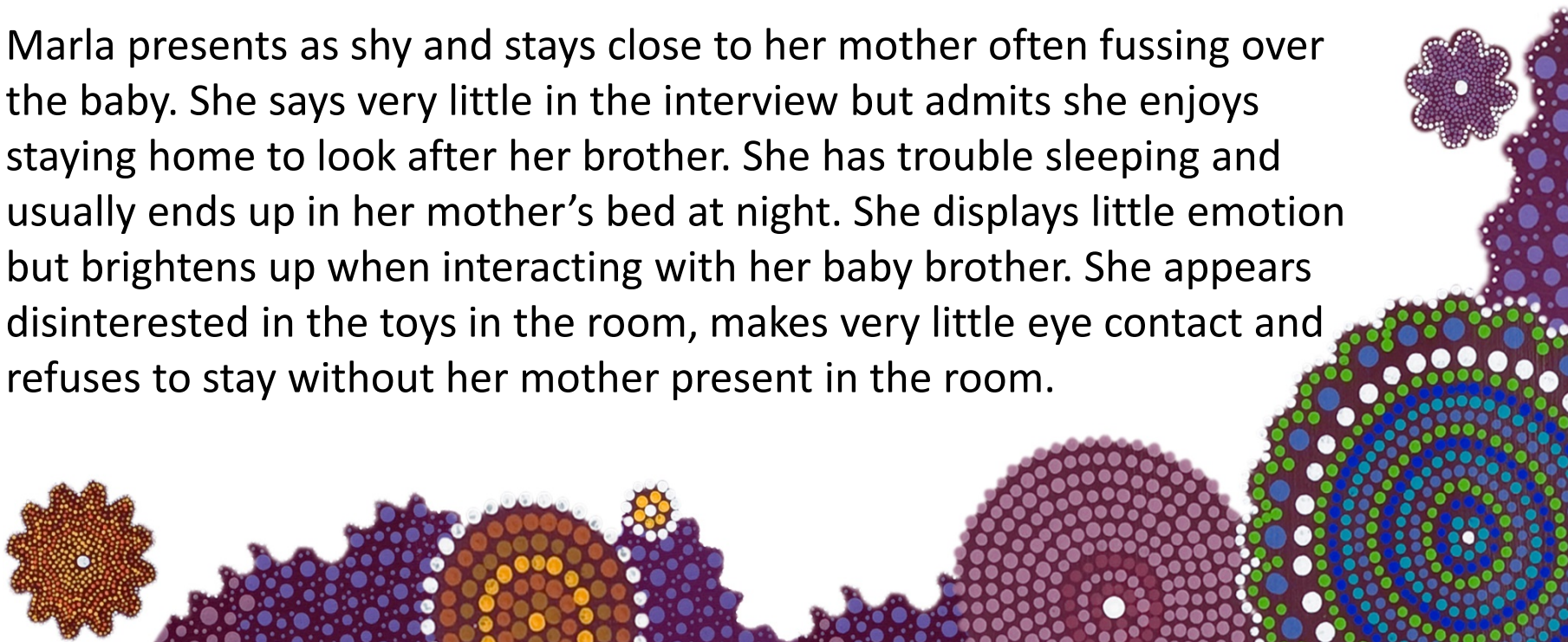
Case Study - Marla

Marla is a ten year-old Aboriginal girl living with her family in a three bedroom state housing townhouse in a large city. She has two brothers aged six years and six months respectively. In the last 12 months, she has suffered the loss of her maternal grandmother aged 54 years through chronic illness, her father aged 30 years from an acute myocardial infarction and a male cousin aged 16 years from suicide. Three years ago, her sister died from sudden infant death syndrome aged 13 months. Marla has lost all interest in attending school and has been spending most of her time at home helping her mother with the baby. Previously, she had been described as a pleasant student and achieved average grades, with good physical health and normal developmental milestones. Marla's mother is concerned about her school refusal, and admits her school attendance has also been patchy over recent years.

Case Study

She is concerned about the school reporting the family to child welfare services and reluctantly accepted the referral to child and adolescent mental health services for assessment. Marla's family is supported by an extensive family kinship system with several aunties and paternal grandparents and there are often additional relatives staying in the home.

Marla presents as shy and stays close to her mother often fussing over the baby. She says very little in the interview but admits she enjoys staying home to look after her brother. She has trouble sleeping and usually ends up in her mother's bed at night. She displays little emotion but brightens up when interacting with her baby brother. She appears disinterested in the toys in the room, makes very little eye contact and refuses to stay without her mother present in the room.

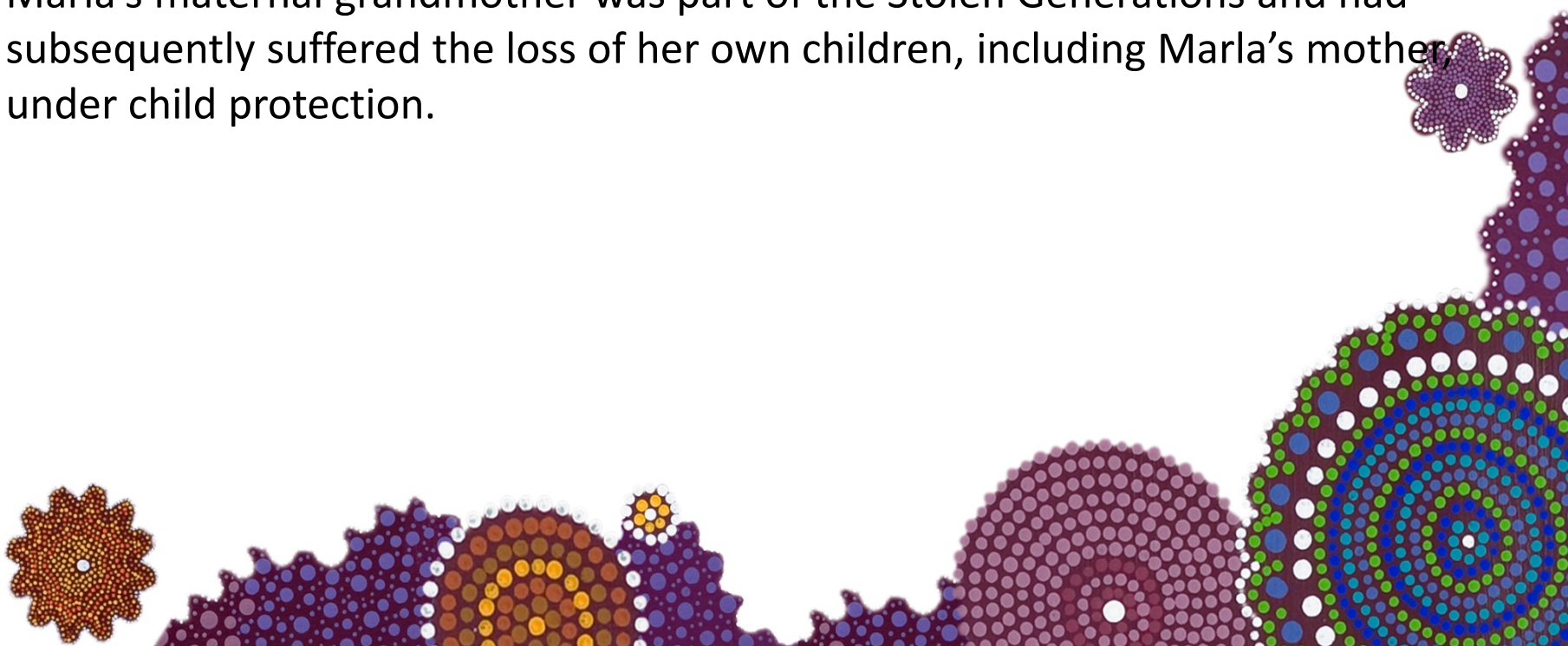


Diagnosis, Mgn't & Prognosis

There are a number of contributing factors to consider to understand Marla.

The magnitude of grief and loss for this family is enormous and when the full history unfolds, there is an even greater level of complexity.

Marla's maternal grandmother was part of the Stolen Generations and had subsequently suffered the loss of her own children, including Marla's mother, under child protection.

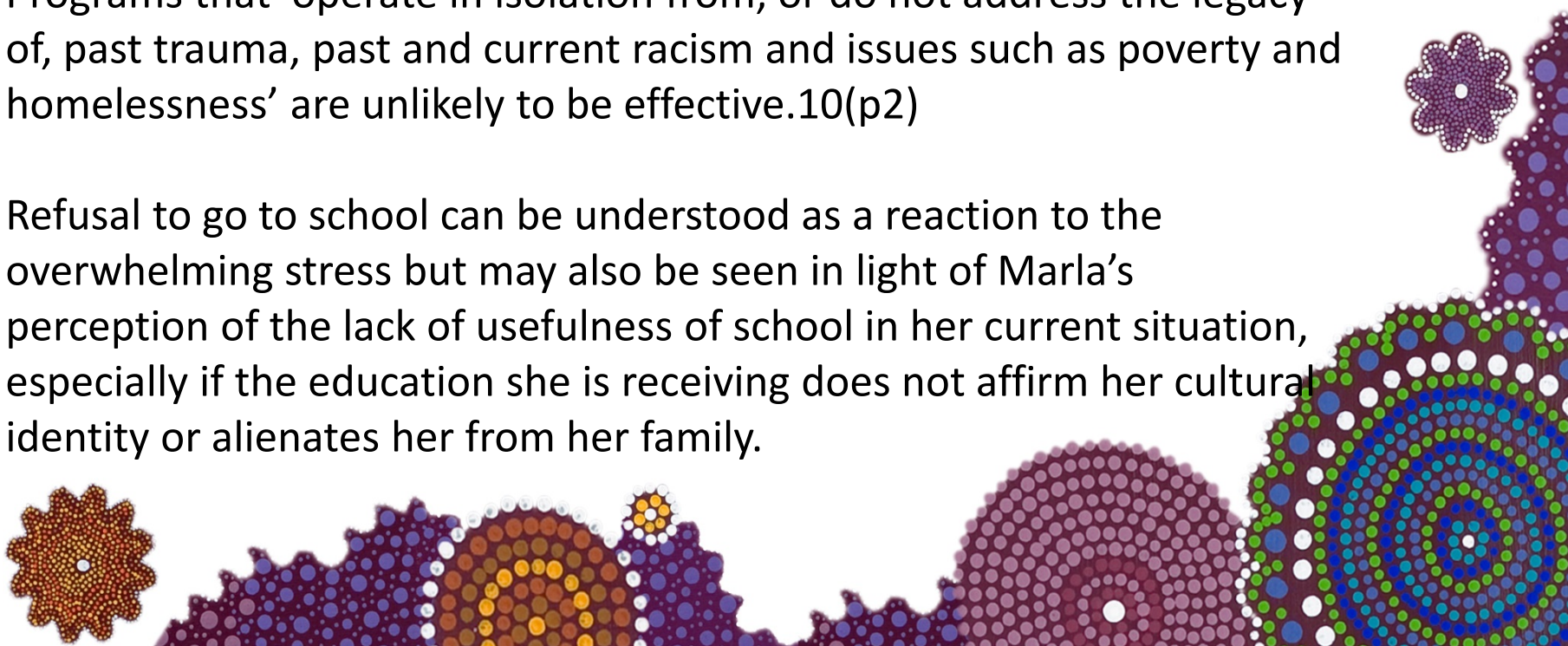


Addressing Trauma and Loss

To really understand Marla, there must be an **understanding of the generational history and the present reality of family and community burden as well as the resilience and strengths that allow a young girl like Marla to cope with life**.

Programs that 'operate in isolation from, or do not address the legacy of, past trauma, past and current racism and issues such as poverty and homelessness' are unlikely to be effective.10(p2)

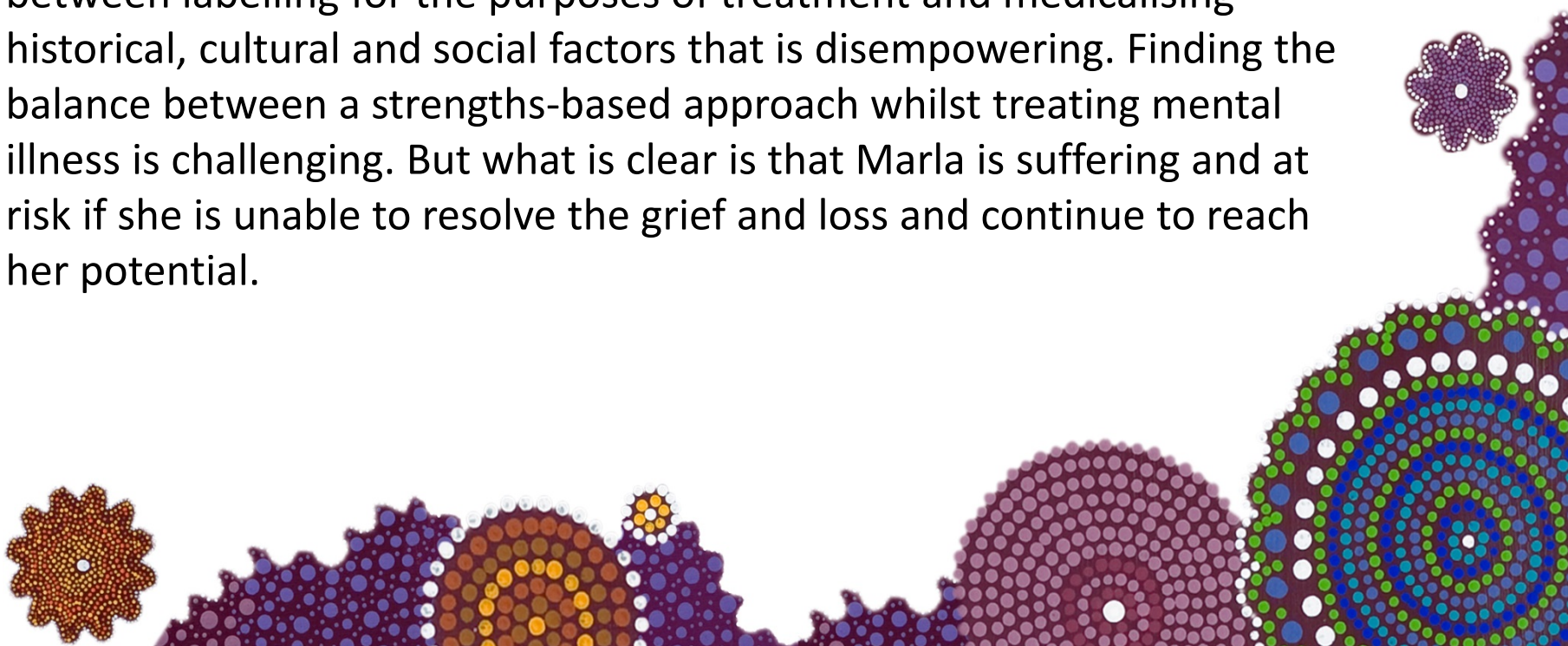
Refusal to go to school can be understood as a reaction to the overwhelming stress but may also be seen in light of Marla's perception of the lack of usefulness of school in her current situation, especially if the education she is receiving does not affirm her cultural identity or alienates her from her family.



Ways of working with Marla

Strategies for working with Marla and her Family need to occur across the sector.

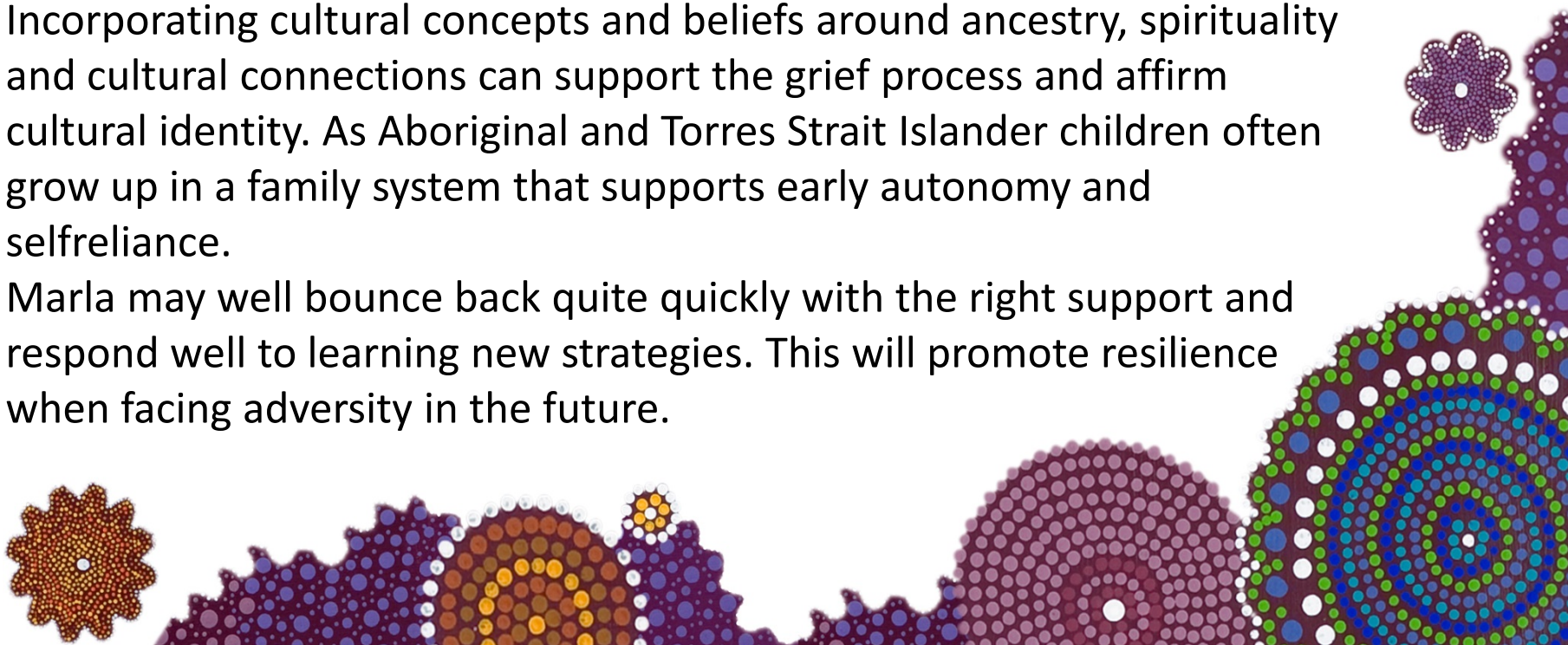
For both teachers and practitioners who are involved with Marla, there will be diagnostic uncertainty, yet the need for a **holistic approach** to assist Marla is obvious given the present scenario. There is a tension between labelling for the purposes of treatment and medicalising historical, cultural and social factors that is disempowering. Finding the balance between a strengths-based approach whilst treating mental illness is challenging. But what is clear is that Marla is suffering and at risk if she is unable to resolve the grief and loss and continue to reach her potential.



For teachers, school counsellors and social workers involved with Marla, working to support Marla and her family may be achieved through good engagement practices such as cultural vouching, obtaining the assistance of Aboriginal Education Workers, Aboriginal mental health workers or Elders from the community.

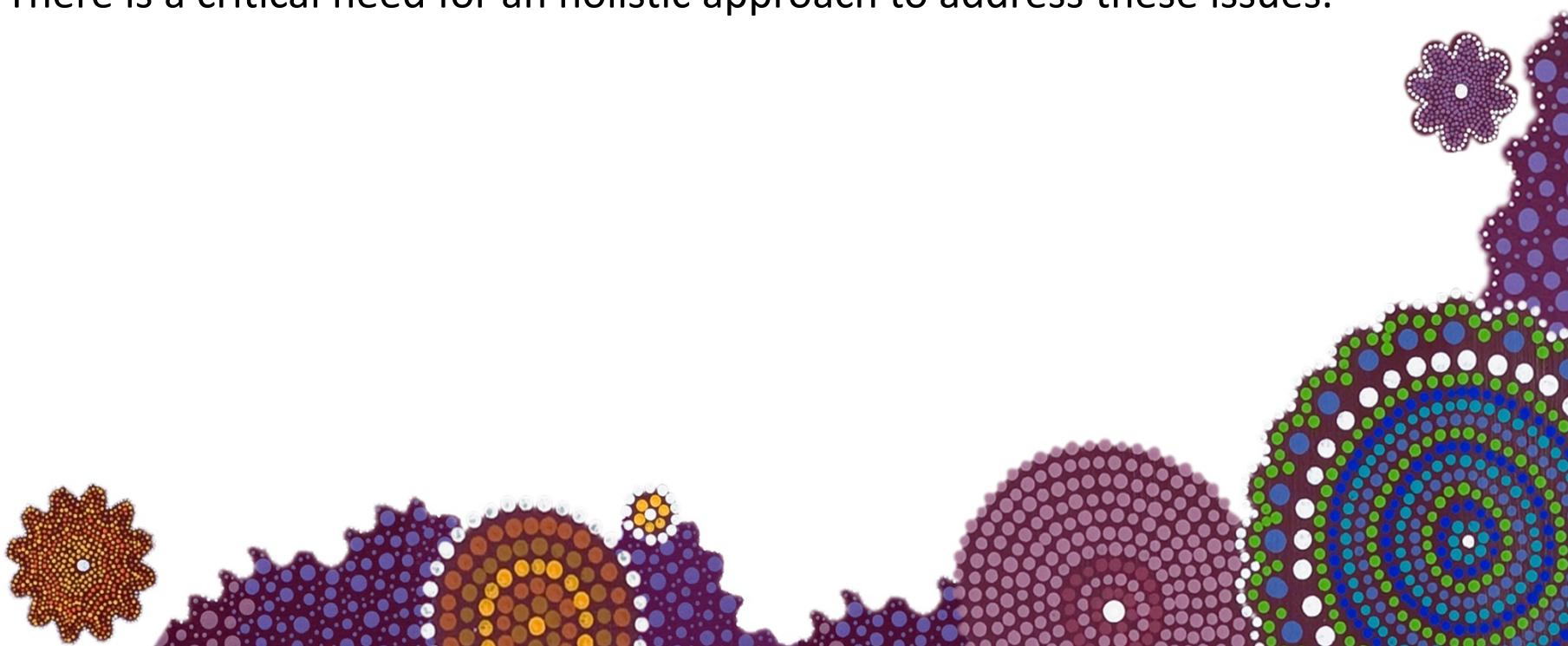
Supporting Cultural Connections Engaging Marla in a narrative to understand the historical burden she carries, provide the opportunity for an empathetic response by the clinician to her present situation, promote her strengths and create a new story for her future. Incorporating cultural concepts and beliefs around ancestry, spirituality and cultural connections can support the grief process and affirm cultural identity. As Aboriginal and Torres Strait Islander children often grow up in a family system that supports early autonomy and selfreliance.

Marla may well bounce back quite quickly with the right support and respond well to learning new strategies. This will promote resilience when facing adversity in the future.



Case Studies

FACTORS INFLUENCING MENTAL HEALTH Although there is a paucity of data on specific child mental health conditions for Aboriginal children and youth, there is evidence of: greater risk for emotional and behavioural difficulties; greater exposure to risk factors and stressful life events; higher rates of suicide.
There is a critical need for an holistic approach to address these issues.



Refflective Exercises

1. How would you consider the transgenerational impact of grief and trauma on child development today?

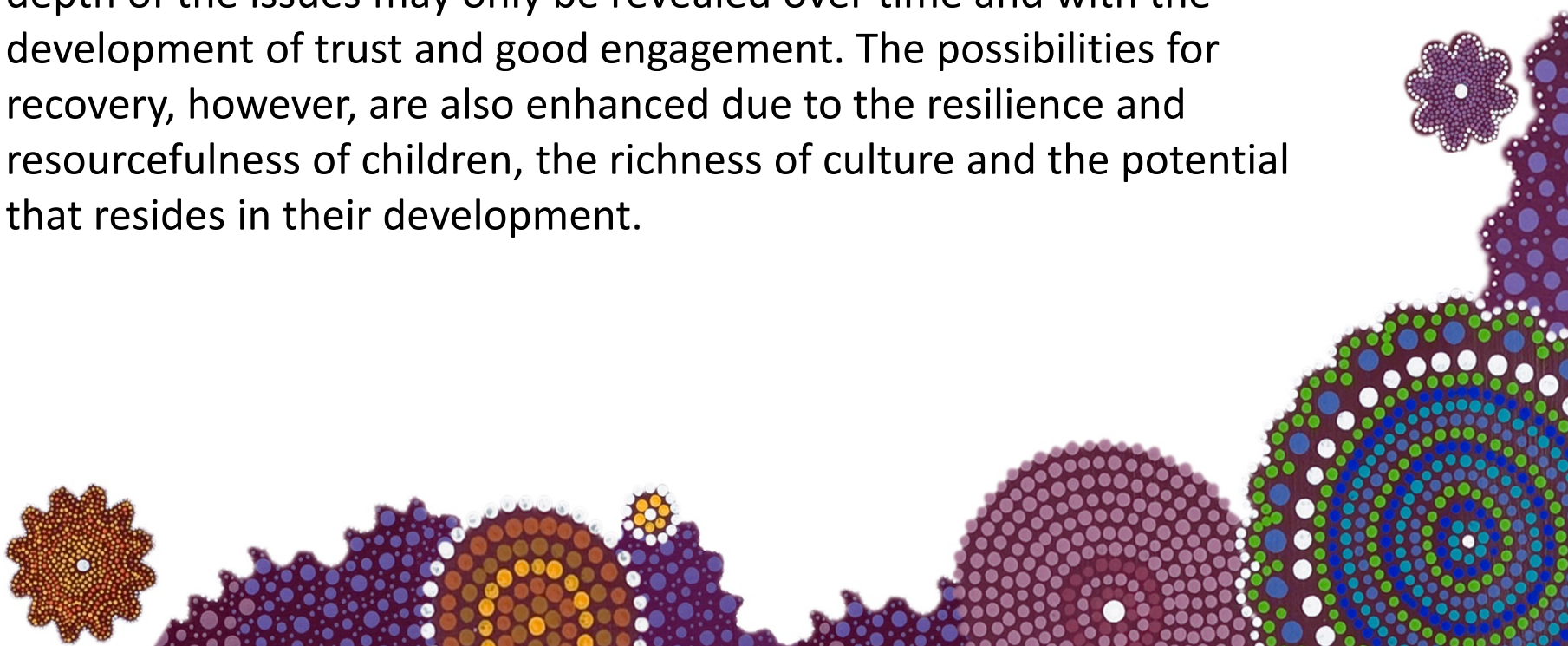
2. How does considering the issues through a trauma informed and cultural lens influence the approach to assessment and management of children with mental health problems?

3. How does your service promote strong cultural identity?

4. What options for cultural therapies are there for inclusion in management?

Conclusion

These case studies illustrate some of the historical, cultural, spiritual, social, psychological and political complexities involved in identifying, assessing and managing significant mental health issues in Aboriginal and Torres Strait Islander children and young people. Although the presenting problems may seem simple at first, the full breadth and depth of the issues may only be revealed over time and with the development of trust and good engagement. The possibilities for recovery, however, are also enhanced due to the resilience and resourcefulness of children, the richness of culture and the potential that resides in their development.



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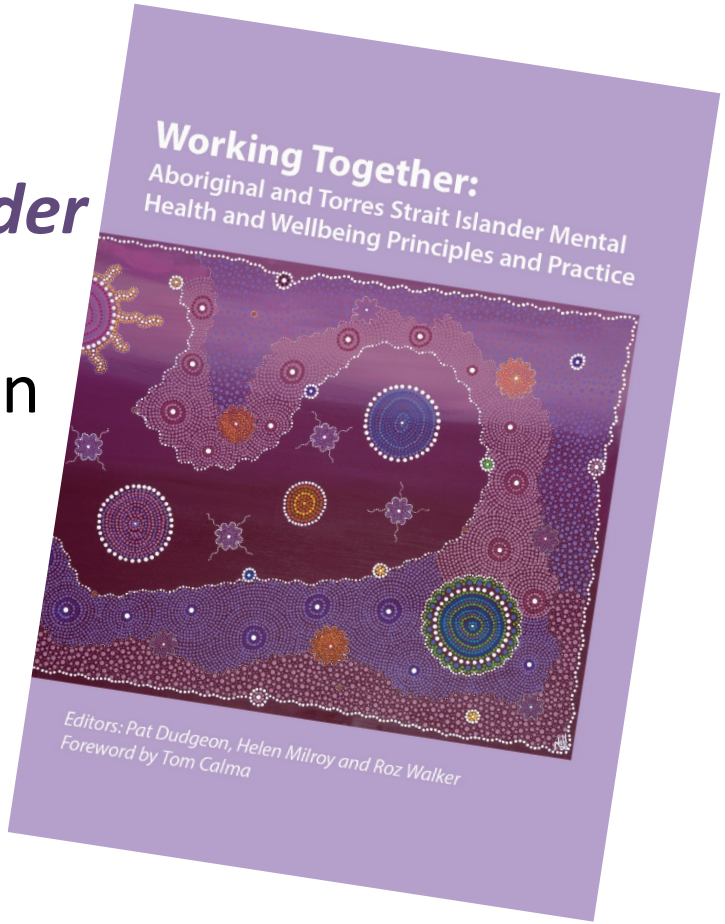

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