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Healthy Community Healthy Mind: An Evidence-based Culturally Sensitive Aboriginal Child and Adolescent Mental Health Program

Abstract

This brief report describes an area of promising practice and a model of care that encapsulates the intersection of non-Indigenous methods and Aboriginal and Torres Strait Islander ways of knowing, being, and doing. The Ballarat and District Aboriginal Cooperative (BADAC) Aboriginal Child and Adolescent Mental Health Program provides evidence-based mental health practice integrating the cultural knowledge and lived experience of Aboriginal staff, clients, and families. The program focus is on building trust with community and clients. This paper presents the outcomes from the first year of the program. Data from referral and assessment processes and outcomes for the young people their families and the community provides preliminary insights into the value of the BADAC model of care. A case study provides a qualitative, in-depth insight into the experiences of a participant in the program. This preliminary evaluation is limited in scope; however, the outcomes are promising and will guide future development of the model to improve mental health for Aboriginal children and young people in the Ballarat district.

Ethics Approval Statement

Privacy protected and data use approved by the Chief Executive Officer, Ballarat and District Aboriginal Co-Operative.

Keywords

Mental health, SEWB, Cultural Safety

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The Ballarat and District Aboriginal Cooperative (BADAC) was established in 1979 by a small group of Aboriginal and Torres's Strait Islander people living in Ballarat, Victoria. BADAC has provided care and support to the local Aboriginal community for more than 40 years. At the time it was established, there was an estimated 353 Aboriginal people within the Ballarat and Western District. (BADAC Annual report, 2021. Currently there are 4,338 people who identify as Aboriginal and/or Torres's Strait Islander peoples in the BADAC service region. Fifty-four percent are aged 24 and under, while 37% are aged 0 to 14; 3.085 live in Ballarat (ABS, 2021).

In November 2020, BADAC received funding to develop and deliver culturally safe assessment and treatment services for Aboriginal youth. The need for a specialist service was already well-established. In 2016, an Australia-wide youth mental health survey stated that **"**across the five-year period, the likelihood of probable serious mental illness was found to be consistently and significantly higher among Aboriginal and Torres Strait Islander young people compared to non-Aboriginal or Torres Strait Islander young people" (Mission Australia, 2016, p. 5)

Accessibility to specialist child and adolescent mental health services is an impediment to early intervention. In one Ballarat private practice, the waiting list is approximately six months. Moreover, mainstream mental health services have intake criteria that only includes clients who have symptoms at the most severe end of the spectrum. The BADAC service is delivered by an accredited mental health nurse with experience providing assessment, treatment and consultation in child and adolescent settings, and also by a young Aboriginal woman who is undertaking further study in mental health and is well-known and respected by the local community.

Model of Care

The model of care provided by BADAC is based on the Victorian Balit Murrup Aboriginal social and emotional wellbeing framework (2017) that states:

> health is holistic, self-determination is a right, kinship is central, Aboriginal cultures are diverse and should be understood, human rights should be respected, Aboriginal

> strengths are acknowledged, and historical trauma, loss, racism, and stigma continue to negatively affect Aboriginal social and emotional well-being. (State of Victoria, 2017, p. 24).

In November 2020, the BADAC Aboriginal Child and Adolescent Mental Health Program spent one month developing program procedures and refining the model of care. This entailed a review of available literature and consultation with Aboriginal staff. The model of care adheres to the principles of delivering a quality evidence-based service within a culturally sensitive and holistic framework. Essentially, the program aspired to combine the best elements of a mainstream Child and Adolescent Mental Health Service (CAMHS) with Aboriginal and Torres Strait Islander conceptions of social and emotional wellbeing (SEWB) (Gee et al., 2014).

Derived from the literature are several principles and practices that underpin the BADAC model of care (Page, et al., 2022). Authentic Aboriginal participation is an essential and non-negotiable ingredient of the Aboriginal Child and Adolescent Mental Health Program. An Aboriginal Youth Mental Health Worker is present at most, if not all, assessments and follow-up sessions to ensure that the assessment is culturally appropriate and safe. Assessments explore questions of Aboriginal identity formation and lived experience. The presence of the Aboriginal Health Worker is essential to this process of culturally sensitive engagement and assessment (Adams et al., 2014; Drew et al., 2010). Increased case care coordination is a collaborative approach and a key element in providing therapeutic culturally sensitive care for service users. Coordination and consultation liaison with schools and other key agencies is undertaken with the permission of client and family, and constitutes a vital component of both the assessment process and subsequent treatment. The role of family and community is paramount. The process is flexible to community needs and BADAC undertakes a comprehensive and holistic assessment to inform the BADAC team about the context and lived experience of the young person, their family and community. The context describes not just the presenting problems, or the contributing, perpetuating, and precipitating factors, but also the strengths which include the

determinants of health such as connection to culture, Country, and supportive kinship relations (Dudgeon et al., 2014).

The model of care acknowledges the cultural understanding and strength-based approach advocated by strong SEWB as a therapeutic intervention for Aboriginal people. This conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community (Gee et al., 2014, p. 57). It is imperative that interventions are tailored to the needs and experiences of clients. Cultural difference in emotional wellbeing and anxiety should also be noted:

> While behaviour and emotions are part of a universal human condition and there will be similarities across cultures, differing constructs of mental health and SEWB may also result in differences in the presentation of some symptoms and in the meaning attached to them. (Walker et al., 2014, p. 414)

The Strong Spirit Strong Mind Model is a culturally appropriate, evidence-based intervention for Aboriginal clients with emotional and social problems:

> The theory of Inner spirit being linked to the mind and influencing people's feelings behaviour and decision-making has enabled working with Inner spirit to be applied in a therapeutic context and incorporates culturally secure cognitive behavioural therapy. (Casey 2014, p. 391)

Summary of Findings: The First Year 2021-2022

The first year of the program was evaluated to assess its impact. Again, it should be noted that these results are preliminary, based on a small sample. Between January 2021 and January 2022, 67 referrals were received with 45 proceeding to the assessment stage. Of the 22 referrals that did not proceed to assessment, 10 were considered a duplication of services being provided elsewhere, six subsequently left the service region, five declined the referral, and one was non-Indigenous.

High referral numbers indicated a strong community demand for a specialised Aboriginal child and adolescent mental health service. Of the completed assessments, 16 were children aged 6-12, 22 were adolescent, and six were aged 18-25. The gender balance

was almost equal with 23 identifying as male, and 22 as female. Eleven clients received the service for three months or less. Long-term support was provided to another five clients for a duration exceeding six months.

Participants completed the Strengths and Difficulties Questionnaire (SDQ), a brief behavioural questionnaire. The measure can be completed by parents, teachers and/or the client if they are aged 11-17. The tool can measure conduct problems, emotional symptoms, hyperactivity, peer relationships and prosocial behaviour. The SDQ is one of the most widely and internationally used measures of child mental health and has been translated in to more than 18 languages (CORC, 2021; Santiago et al, 2021). Globally, it is generally regarded as reliable and valid. Some researchers do, however, have reservations about the adaptability of the SDQ. Williamson (2014) suggested that the peer problems subscale does not appear to be completely appropriate for Aboriginal children (Williamson, 2014 et al., as cited in Santiago et al., 2021, p. 2). Nevertheless, a decision was made to use the SDQ. It should be noted that the measure is only one of the arrows of evidence contributing to the assessment process and should never be utilised in isolation from the broader assessment process (Adams et al., 2014; Drew et al., 2010). It can, however, be useful in providing quantitative evidence of intervention outcomes. It is also useful as a point of departure for in-depth discussions on the occasions where there is a disparity between child and parent observations. The BADAC team felt that, for the most part, clients and families found the questionnaire user-friendly. Deep engagement is a cornerstone of any assessment and adopting a yarning approach works best (Lin et al., 2023, Lin et al., 2016). For example, some clients and their family members were more relaxed and comfortable outside the office setting, using a walk and talk approach.

Based on the SDQ, externalising disorders were the most common behavioural manifestation, particularly in the primary school age group. Clients experiencing anxiety and mood disorders also presented in high numbers. It is also notable that five clients did not conform to SDQ behavioural categories. In these cases, the broader approach to assessment yielded dividends and it was observed that despite early life traumatic

experiences, some clients benefited from long-term, stable, nurturing family environments. The role of BADAC was to validate and strengthen these relationships, which in many cases have been life-giving.

Of the 22 cases, 10 clients completed outcome measures before and after service provision. While the completion rate of just below 50% is a limitation of this report, the results were promising. Five respondents demonstrated clinically significant improvement, another three exhibited moderate improvement, and two clients had no change. No-one exhibited a deterioration in mental state.

An Illustrative Case Study

To illustrate the holistic BADAC model of care and assessment processes, the following case study is presented. The client's name and identifying details have been changed to preserve confidentiality.

Neville is an Aboriginal 16-year-old male who presented with school refusal of two to three years duration. This was having a deleterious impact on his wellbeing, educational and social prospects. Neville feared that he would act in a way that would be negatively evaluated, and in response to this, social situations were avoided or endured with considerable fear and discomfort. Contributing and precipitating factors included various traumatic events such as family violence, the prospect of parental hospitalisation and the death of a pet. School refusal was exacerbated by avoidance, which entailed walking out of classrooms and getting family members to pick him up from school. The rescue efforts were well-intentioned but served only to reinforce his belief that escape was the best option.

Using a Subjective Unit of Discomfort Scale (SUDS), Neville rated school attendance as the most intensely uncomfortable situation. He regarded the experiences as very uncomfortable; he was unable to concentrate and wanted to escape. Other social situations produced moderate levels of anxiety.

Neville and his family were actively seeking help. There were improvements in the family environment with his father reducing his alcohol intake and commencing employment. Neville displayed some sporting prowess and the ability to make and sustain friendships.

Neville identified as Aboriginal from the paternal side of the family, although his father had only minimal interest in his Aboriginal heritage. The degree of Neville's cultural engagement was moderate.

The assessment process spanned three sessions and entailed contributions from the client his mother, aunt, and the school. Following assessment, it was concluded that Neville was experiencing social phobia with elements of separation anxiety and acute stress. Treatment was multifaceted, including Cognitive Behavioural Therapy. The treatment was family inclusive and where possible used key family members as treatment partners.

The Aboriginal Youth Mental Health Worker was also able to facilitate a referral to the BADAC Aboriginal Child and Adolescent Mental Health Program. The program's role was to support Aboriginal adolescents with everyday issues such as self-confidence and maintaining healthy relationships. The purpose of this intervention was twofold. Firstly, it exposed Neville to cultural influences such as yarning circles, visits to cultural sites and talks from Elders, while also providing an opportunity for supportive graded exposure to confronting social situations.

The return to school took approximately three months. Initial efforts were unintentionally thwarted by a well-meaning aunt who picked her nephew up from school whenever he called in a distressed state. To address this issue, the team convened a family meeting to reiterate the importance of managing anxiety within a graded supportive environment. To support this graded approach, the school provided Neville with support to stay at school, while allowing temporary withdrawal from the classroom.

In the following months, school attendance improved markedly. While there were still periods of discomfort, stress and anxiety, Neville began to utilise new skills such as breathing techniques which enabled him to better manage his anxiety.

In facilitating a return to school, the role of the Aboriginal Youth Mental Health Worker has been pivotal. This has entailed transporting the client to school and coaching him through gradually diminishing levels of stress using relaxation techniques and informal cognitive therapy, which was sometimes labelled 'strong thinking'.

By February 2022, Neville had received support from the Aboriginal Child and Adolescent Mental Health Program for approximately 10 months. He reports being proud of his increased confidence and improved social relationships. The client has obtained casual employment and school attendance has improved from zero to approximately 90%. At review, the client requested that the service continue as he still experiences periods of vulnerability and has found the service to be beneficial.

Discussion

The case study resulted in positive outcomes for Neville and family. BADAC believes that the model of care assisted this process through the application of core principles. The presence of an Aboriginal team member in providing support and therapeutic intervention was inspiring to the client, who now aspires to work with people in the health and welfare field or hospitality.

Case coordination was important, particularly building a collaborative relationship with the school. Involving the extended family was also imperative, and in response they did their best to provide increased stability support and emotional coaching. Past traumas were acknowledged and counselling options for other family members encouraged.

BADAC was proactive in encouraging and supporting attendance in Aboriginal cultural youth groups. Initially, attending groups was moderately anxiety-provoking but this abated as time progressed.

The treatment was family-inclusive but also relied on an evidence-based intervention. The process was generally informal and often entailed a conversational yarning approach whilst walking. Continuity of care from referral to assessment and therapeutic intervention helped build trust engagement and belief.

Outcome measurement via SDQs showed scores had improved markedly, which reinforced the supplemental rather than central role of outcome measures.

Conclusions

This paper describes a busy and rewarding first year of an Aboriginal Child and Adolescent Mental Health Program Team. The model of care promoted culturally sensitive practice within an evidence-based framework. The successful application of this process was noted in the case study. Key features of the BADAC model of care included culturally appropriate assessment and intervention, a strong emphasis on care coordination, enhanced family involvement and a key ingredient of an Aboriginal presence in treatment and assessment. The model provided cultural learning opportunities for the clinicians, but

also presented an opportunity for Aboriginal Health Workers to gain experience and confidence.

Completed outcome measures resulted in promising outcomes, but it is noted that the small sample size made it difficult to draw any statistically significant findings. Continued service review is important and will allow BADAC to adapt and develop its practice and explore further opportunities to refine and enhance the role cultural determinants in everyday practice. At this early point in the program development, the model of care appears suited to community need and is worthy of further exploration.

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