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Mental health in Indigenous settings
Challenges for clinicians

Background

Mental health problems in Aboriginal and Torres Strait Islander peoples are common, changing and challenging. Particularly in remote settings, doctors will need to untangle the complex interplay of culture, context and clinical significance.

Objective

This paper emphasises the importance of local knowledge and cultural respect in complementing clinical competence in the management of Aboriginal and Torres Strait Islander peoples with mental health problems.

Discussion

Anxiety, depression, psychosis, self-harm and problems of childhood and old age are used to exemplify differences by comparison with practice in non-Indigenous populations.

Keywords

health services, Indigenous; Indigenous population; mental health

Twenty-five years ago I was in the Kimberley undertaking research on Aboriginal suicide and talked with doctors who informed me that other than alcohol, mental health problems, including anxiety and depression, were rare. This was NOT what I learned from Aboriginal informants.[1] So, how to explain the opinions of my colleagues? Well, many of those doctors had spent most of their careers in metropolitan Australia where Aboriginal and Torres Strait Islander peoples were, in the 1970s and 1980s, far less visible than is the case today (indeed, hardly present at all in medical curricula). Practitioners arriving in remote settings brought preconceived notions that local 'clinical wisdom' often confirmed.

As I had been in the Kimberley in the1960s and 1970s, I was aware that the pace of social change over those decades had been furious, with many social and behavioural consequences, including an increased prevalence of mental ill health – alcohol was but the most obvious. Indeed, in the years since there has been a 'cascade' of new problems, each of which has occupied clinical and policy attention. So, starting around the 1970s there were, serially, alarming increases in alcohol abuse, interpersonal violence, adult suicide, adolescent and child suicide, disability related to fetal adversity (including exposure to alcohol), cannabis abuse and, most recently, psychosis. Contemporary and developmental context (the neurodevelopmental environment of pregnancy and early childhood) are critical to understanding this cascade.

Clinical challenges

It is now clear that the burden of mental health disorder in Aboriginal and Torres Strait Islander populations is high.[2,3] While there are differences in the prevalence of certain conditions cross-culturally, it is prudent to be guided by the assumption that if it can happen in the mainstream it also can in an Aboriginal setting. However, some conditions, for instance anorexia nervosa and obsessive–compulsive disorder, rarely come to attention. Unsurprisingly, even in remote communities, 'common' conditions are likely to be so and given high levels of stress, if anxiety and depression are not being identified it

is more likely to be attributable to service factors than prevalence. Less common but challenging conditions that may present in crisis are psychoses and self-harm. And there are conditions that are important but, until recently, have been relatively 'hidden'. Two from opposite ends of the life cycle are attention deficit/hyperactivity disorder and dementia.

To exemplify some general principles I will draw on these six conditions to consider similarities and differences by comparison to mainstream presentations. As important as communication is in primary care generally, it is particularly so in this cross-cultural context.[4]

Similarities

The most important similarity is that, broadly, the underlying phenomenology is the same. That is, having a particular condition or issue in mind, if one asks the right questions of patients who identify as Aboriginal and Torres Strait Islander, and informants, one can usually elicit responses that enable diagnosis. This is important; cultural competence in this arena is about developing and sustaining relationships to support clinical acumen – respectful practice. It demands being alert to the possibility of both pathologising culture AND of culturally rationalising pathology, which can be as simple as not asking. So, in pursuit of cultural sensitivity one should not leave clinical vigilance at home.

Differences

Differences can be considered in terms of presentation and expression. In terms of the former, the service context is clearly important and there will be significant differences between community-based settings with a stable local workforce and visiting services with limited Indigenous capacity on the ground.

Of patients experiencing these conditions, those most likely to seek help from a primary care practitioner will be people with anxiety and depression, because these are common and they will often be associated with somatic symptoms and/or comorbid illness. Doctors' roles thus provide a privileged opportunity for identification and management. Indeed, it can be argued that there is a case for inquiring with all patients and there is a range of screening instruments (clinicians should be familiar with what is being used locally). Tools evaluated in Aboriginal and Torres Strait Islander contexts include the Patient Health Questionnaire (PHQ-9)[5] for depression and the IRIS,[6] which screens for substance use and mental health problems – primarily anxiety and depression. However, experienced clinicians usually have their own shorthand questions adapted to local idiom. For instance, tapping into the psychological and physical experiences of anxiety and depression with variants of: 'Have you been feeling sad or down in the dumps?' and 'Have you been feeling slack, like you've got no energy?' for depression, and 'Have you been feeling nervous or worried?' and 'Have you been jumpy or like you can't sit still?' for anxiety. Paraphrasing is helpful.

Patients with psychoses are likely to present in crisis and be identified by others. Psychotic disorders are increasingly common in Aboriginal populations[7] and often caused or exacerbated by substance use, particularly cannabis (the Severity of Dependence Scale (SDS) is being used in Aboriginal settings).[8] Paranormal experiences (visions and voices) and beliefs are an expected accompaniment to grieving or traditional activities, particularly in remote and tradition-oriented populations. Sorcery is also commonly invoked to 'explain' illness or death, particularly if unanticipated. Furthermore, threats of sorcery are increasingly spread through social media by Aboriginal and Torres Strait Islander teenagers, often interwoven with ideas drawn from film and television. Differentiating these from psychosis incorporating traditional themes can be difficult. The best guide is to take into account history, context and the opinion of trustworthy, local Aboriginal and Torres Strait Islander informants (clinicians should ask directly about 'black magic' and be familiar with the local term). Rather than setting up illness and traditional beliefs as mutually exclusive, it is helpful to acknowledge each – 'I know some young men think this way because of black magic but some also get that way because of drugs or because of mental problems. Sometimes it's both ways. With what he's saying now, is that your way or do you think it could be a mental problem too?' In some settings this approach also provides the opportunity to work collaboratively with (and to learn from) traditional healers (two of whom were recognised by the Royal Australian and New Zealand College of Psychiatrists for their contributions to Aboriginal mental health[9] – differential diagnosis is not the exclusive preserve of medical professionals).

Traditional themes may also be raised in the context of threatened or actual self-harm. While 'sorry cuts' as part of grieving in certain remote settings occurs, history and context should, again, enable non-traditional self-mutilation to be identified (this is more likely to occur in younger, troubled and often intoxicated individuals, with the behaviours being socially 'disintegrative' rather than integrative;[10] again, consult with local informants). More challenging is a person at risk of suicide who describes voices and spirits, usually of someone deceased, 'calling' for them. How this is construed is less important than that it be taken seriously, particularly if the deceased person died by suicide. Practitioners should be aware that self-harming[11] is more common in Aboriginal and Torres Strait Islander peoples, as is completed suicide, and those dying are more likely to be younger and to have substance-misuse problems.[12] Impulsivity, then, is a major issue and ensuring safety is, accordingly, critical (also common with self-harm and interpersonal violence is 'jealousing' and intense arousal associated with being either subject or object). For children and teenagers, disengagement (from school, family and peers) and exposure to others' self-harming behaviours are associated with elevated risk and need to be asked about.

Finally, problems in children and the elderly tend to be hidden. The behavioural problems of Aboriginal and Torres Strait Islander children are often associated with neurodevelopmental delay compounded by education system failure, particularly in remote settings. Rates of referral from schools may be low because teachers in remote settings are often

quite junior and overwhelmed. There may be assumptions (conscious or not) that the behaviours reflect 'race' rather than circumstantial or clinical issues, or that purported causes, for instance fetal alcohol syndrome and fetal alcohol spectrum disorder, cannot be remedied. Such assumptions presume unmodifiable factors that support fatalism, which medical practitioners can have an important role in combating.

Resignation on the part of service providers (and sometimes parents) is also contributed to by the burden resulting from a youth dependency ratio (the proportion of children and youth to adults) that is roughly twice that in the broader society. The opposite contributes to the 'invisibility' of mental health problems in the surviving elderly, who constitute a significantly smaller proportion of the Aboriginal and Torres Strait Islander population. While the numbers may be small, cognitive decline is more common than would be expected reflecting a range of factors.[13,14] In remote settings clinicians should be familiar with the Kimberley Indigenous Cognitive Assessment or KICA-Cog (www.wacha.org.au/kica.html) but it is a mistake to presume that this is appropriate for all patients who identify as Aboriginal and Torres Strait Islander and, particularly in urban settings, the mini-mental state examination may be a better option. This is a judgement, as is contextualising the result in terms of relative restrictions to activity and participation by comparison to peers and the past. Again, reliable informants and history are critical.

Conclusion

Working with Aboriginal and Torres Strait Islander peoples is a privilege. To be effective requires respect, curiosity and continuity.[15] Local, rather than esoteric, knowledge is important, as is engagement. For instance, never underestimate the importance of a cup of tea.[16] Whatever one's style, one needs to be comfortable in one's own skin and be clear about one's role. Given the context of disadvantage in which such practice occurs, that is sometimes difficult, and it is worth recalling Leonard Syme's caution not to lose sight of what we can do (clinically) in pursuit of what of what might be done (socially):

> 'Insisting only on fundamental and revolutionary social change is dooming us to programs that will take years and generations to take effect. Since it is difficult to implement such major social change, it is easy to ignore inequalities because, they say, nothing can realistically be done about them. Moral outrage about inequalities is appropriate but may be self-indulgent. If we really want to change the world we may have to begin in more modest but practical ways.'[17])

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