



# LITERATURE REVIEW

into service model approaches to youth  
mental health issues in regional areas

Prepared by:



Joyce Lewis-Affleck, Eudaimonia  
Consulting for Anglicare WA  
September 2017



Anglicare WA acknowledges WA Primary Health Alliance (WAPHA) for  
providing funding in its role as the operator of the Country WA PHN

# Contents

Background and methodology	1
Young people’s mental health	2
Cultural conceptions of social and emotional wellbeing and implications for mental health services	4
Help seeking	7
Formal help seeking	7
Sense of efficacy and trust	8
Informal help seeking	8
Type of help needed	9
Barriers and facilitators of help seeking	10
Engagement of hard to reach young people	12
Service use	13
Aboriginal young people’s engagement with services and programs	13
Facilitators of engagement	13
Facilitators of engagement at the practitioner level	14
Facilitators of engagement at the system level	15
Participation and engagement for mental health promoting effects	16
Service delivery approaches and strategies	17
Culturally appropriate services	17
Supporting young people	19
Gaps and emerging issues	22
Conclusion	23
References	24

# Background and methodology



Anglicare WA is examining methods for delivering mental health service support to young people in the Pilbara in Western Australia. Targeting the most relevant research and publications, this review was commissioned to provide a critical analysis of approaches to wellbeing and the engagement of hard to reach young people in mental health supports, with a particular focus on Aboriginal young people.

In conjunction with an Environmental Scan and Customer Journey, this Literature Review will provide insights into a Human Centred Design (HCD) process for service modelling. A conceptual map of key themes and a summary of key findings from the Literature Review was presented at a Data Synthesis Workshop held in Perth on 25 August 2017.

The review of literature initially used sources of knowledge from published literature guided by Anglicare WA project staff. Selection of literature to include was based on the following focus areas:

- Youth mental health service delivery methods and strategies.
- Target groups of young people with mild, moderate and severe mental health issues.
- Particular emphasis on rural and remote contexts.
- Particular emphasis (though not exclusive) on target group of Aboriginal young people.
- Examples from local, national and international contexts.

A total number of 76 sources were collected and scanned, 66 were selected for more thorough review and 48 were cited in this review. A key source was the Australian Institute of Health and Welfare (AIHW) Closing the Gap Clearinghouse, in addition to those supplied by Anglicare WA project staff. Unpublished literature was investigated with Google using the focus areas as search terms. The sources were reviewed and summarized.

It is not possible in this review to do justice to all the bodies of research and the philosophy underpinning the focus areas. It explores a number of related concepts to contribute to the HCD process for this project.

This review encompasses findings relevant to young people’s well-being in general, with a particular emphasis on Aboriginal young people due to the relatively high percentage of Aboriginal young people in the Pilbara (22% of young people aged 15-24), high rates of mental health problems among Aboriginal young people and the barriers they face in seeking assistance for mental health issues. The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People (Zubrick et al., 2005) found that 20.5% of Aboriginal children in WA aged 12-17 years were at high risk of clinically significant emotional or behavioural difficulties, compared to 12.5% of non-Aboriginal children. A further 9.4% of Aboriginal 12-17 year-olds in WA was at moderate risk.

While this literature review focuses on mental health and wellbeing, there are numerous social, economic and structural forces that impact upon young people’s wellbeing. Particularly for Aboriginal residents in the Pilbara, intergenerational trauma, racism and entrenched disadvantage are considerable factors in young people’s social and emotional wellbeing and their engagement with services.

The term Aboriginal is used in preference to Aboriginal and Torres Strait Islander as this is the preferred usage within Western Australia. The combined terminology of Aboriginal and Torres Strait Islander peoples is often used in the national context and the term Indigenous is used in the national and international context. No disrespect is intended.



# Young people's mental health

Prevalence data for young people is reported from a number of sources including the Mental Health of Children and Adolescents, Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing reporting on 12-17 year olds, the ABS Mental Health of Young People, 2007 reporting on 16-24 year olds, The Western Australian Aboriginal Child Health Survey, the Social and Emotional Wellbeing of Aboriginal Children and Young People for 12-17 year olds, and the 2016 Mission Australia Youth Survey reports from 16-19 year olds.

In 2015, 12-month prevalence of mental disorders among 12-17 year-olds was 14.4% (15.9% for males and 12.8% for females). Young people were more likely to have Anxiety disorders (7%) (7.7% females, 6.3% males), than other conditions such as ADHD (6.3%) (9.8% males, 2.7% females), Major Depressive Disorder (5%) (5.8% females, 4.3% males) and Conduct disorder (2.1%) (2.6% males, 1.6% females) (Lawrence et al. 2015).

Children and adolescents who lived outside of the greater capital city areas had higher rates of mental disorders compared with those living in other areas. This was particularly so for males, with almost one in five (19.6%) young males residing outside of the greater capital city areas having had a mental disorder in the previous 12 months (Lawrence et al. 2015).

In 2007, approximately three-quarters (76%) of all young people assessed their own mental health as excellent or very good. However, around one-quarter of all young people (16-24 year olds) had a mental disorder in the previous year (approximately 26%). Young people were more likely to have Anxiety disorders (15%) and Substance Use disorders (13%) than Affective disorders (6%) (ABS, 2007).

Young women were more likely than young men to have had any mental disorder in the year prior (30% compared with 23%). Young women were also around twice as likely as young men to have an Affective disorder (8% compared with 4%) or an Anxiety disorder (22% compared with 9%). Substance Use disorders were more common in young men (16%) than in young women (10%) (ABS, 2007).

The Mission Australia Youth Survey (2016) found that coping with stress, school or study problems and body image continued to be the top three issues of personal concern for young people for both Aboriginal and Non-Aboriginal respondents.

Coping with stress was the top issue of concern, with 44.4% of respondents indicating that they were either extremely concerned (20.1%) or very concerned (24.3%) about this issue. School or study problems was a major concern for 37.8% (extremely concerned: 15.3%; very concerned: 22.5%) of young people. Body image was also an important issue of concern for 30.6% of respondents (extremely concerned: 13.0%; very concerned: 17.6%). Around one in five respondents were either extremely concerned or very concerned about depression and family conflict. Just over one in ten highlighted that suicide was also a concern.

For around half of Aboriginal and Torres Strait Islander females, coping with stress was a major concern (extremely concerned: 26.8%; very concerned: 24.5%), compared with around one quarter of Aboriginal and Torres Strait Islander males (extremely concerned: 13.1%; very concerned: 11.7%).

Females were also more concerned about school or study problems, with 43.3% (extremely concerned: 20.3%; very concerned: 23.0%) indicating that this was a major concern, compared with 25% of males (extremely concerned: 14%; very concerned: 11%).

Concerns about body image were considerably higher among females, with 43.0% (extremely concerned: 21.4%; very concerned: 21.6%) indicating that body image was a major concern, compared with 19.9% (extremely concerned: 11.0%; very concerned: 8.9%) of males.

For 35.6% of Aboriginal and Torres Strait Islander females (extremely concerned: 15.6%; very concerned: 20.0%) and 19.9% of males (extremely concerned: 12.2%; very concerned: 7.7%) family conflict was a major concern (Mission Australia, 2016).

A large proportion of individuals, both Indigenous and non-Indigenous, who have substance misuse disorders have co-existing mental health disorders (Blankertz &

Cnaan, 1994). Roxbee and Wallace (2003) report that there are high rates of co-morbidity, as well as complex patterns in causality and treatment, which are unique to Australian Indigenous populations.

The 2014-15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that 29% (25% of males and 34% of females) of Aboriginal and Torres Strait Islander people who self-reported a mental health issue also reported harmful use of, or dependence on drugs or alcohol. Almost one-quarter (23%) of Aboriginal and Torres Strait Islander people reported having both a mental health condition and one or more other long-term health conditions. The NATSISS also found that mental health conditions were less likely to have been reported by young people (22%) than by those in older age groups (ranging from 30% to 35%).

Mental health conditions were twice as likely to have been reported by Aboriginal and Torres Strait Islander people in non-remote areas than in remote areas (33% compared with 16%). NATSISS also found that Aboriginal and Torres Strait Islander people with a mental health condition were almost three times as likely to have experienced high or very high psychological distress levels (60%) as those with other long-term health conditions (21%) or no long-term health condition (22%).

Similar proportions of Aboriginal and Torres Strait Islander people, with or without a mental health condition, exceeded alcohol consumption guidelines for lifetime risk (14% to 16%) and single occasion risk (30% to 33%) in 2014-15. However, Aboriginal and Torres Strait Islander people with a mental health condition were more likely to be a daily smoker (46%) and to have used substances in the last 12 months (39%).

In 2014-15, Aboriginal and Torres Strait Islander people with a mental health condition were more likely than those without a mental health condition to have experienced one or more stressors in the last 12 months. The majority (84%) of people with a mental health condition reported experiencing one or more stressors, compared with 64% of those with other long-term health conditions and 60% of people with no long-term health condition.



Aboriginal and Torres Strait Islander people with a mental health condition were also more likely to have been removed, or to have had relatives removed, from their natural family (50%) and to have experienced racial discrimination in the last 12 months (44%) than were people with other long-term health conditions (42% and 31%, respectively) and those with no long-term health condition (34% and 28%, respectively).

In 2014-15, Aboriginal and Torres Strait Islander people with a mental health condition were more likely to have experienced problems accessing health services (23%) than were people with other long-term health conditions (13%) or no long-term health condition (10%).

A study of Aboriginal child and adolescent mental health published in the Medical Journal of Australia found that Behaviours such as becoming withdrawn and misbehaving at home or school were considered to be problematic, and participants in the research study thought that these behaviours were sometimes caused by physical or social issues. Concerns were raised in the study about Aboriginal young people being incorrectly diagnosed with mental health problems due to under recognition of such issues (Williamson, 2010).

Aboriginal and Torres Strait Islander peoples are dying from suicide at twice the rate of other Australians. The greatest difference in rates of suicide between Aboriginal and Torres Strait Islander people and non-Indigenous people were in the 15-19 years age group for both males and females. Suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 years were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate was 4.4 times higher (Australian Bureau of Statistics (ABS, 2010b).



# Cultural conceptions of social and emotional wellbeing and implications for mental health services

Young people have a broad, holistic understanding of health and what they require to maintain their health and social and emotional wellbeing (Van Dyke, Maddern, Walker, 2014). Young people refer to being healthy as including eating healthy foods; participating in physical activity; being connected with friends, family and community; avoiding or being careful around drugs and alcohol; finding inner contentment; being resilient; and maintaining a good level of self-esteem. They also understand that health is affected by a range of social determinants.

The provision of services and programs to young people need to account for different conceptualisations of health, mental health and mental illness, family and community among Aboriginal and non-Aboriginal people.

Culture plays a significant role in how people understand health, the causes of poor health and appropriate treatments. Western psychiatric conceptualizations of mental illness describe it in terms of an underlying function of the brain. Yet, even within mainstream Western views, there has been a broadening conceptualisation of mental health and wellbeing. The concept of positive mental health and optimal functioning and its contribution to all aspects of human life is now well established in the literature.

An understanding of the differences between a Western view of health situated within the biomedical model of individual responsibility and the Aboriginal view of 'wellbeing' which is holistic, encompassing social, emotional, mental, physical, cultural and spiritual dimensions is essential to the provision of good health care for Aboriginal people (Dudgeon et al., 2014; Westerman, 2014). This holistic concept does not just refer to the whole body but to the inter-relations and interconnections of the whole community.

The differences in Western and Aboriginal perceptions of mental illness is reported in Vicary and Westerman (2004) where Aboriginal participants consistently perceived the course and treatment of depression as having different causes than that of non-Aboriginal Australians. Depression and other traditional culture bound disorders exist in Aboriginal people in Western Australia which do not conform with Eurocentric perceptions, but rather to an Aboriginal Australians' conceptualisation of health and wellbeing (Westerman, 2004). These often relate to Diagnostic and Statistical Manual of Mental Disorders (DSMIV) criteria but are understood to have a different cause and therefore require a more appropriate and varied treatment regime.

Vicary and Westerman (2004) report that almost three in four Aboriginal respondents (72%) did not perceive depression as a state that could be addressed via treatment. Instead they perceived it as a characteristic of the individual concerned stating *'that's just the way he is'*. Participants stated that depression in Aboriginal communities often went unnoticed and subsequently the traditional methods of interpretation and healing were not activated. In their view, mental illness moved from characterological to pathological when the illness became visible (e.g. crying in public regularly, high-risk behaviour) or resulted in behavioural aberrations (e.g. suicidal behaviour).

Participants argued that once the illness was recognised individuals received mental health services, however this was typically when their illness had become acute. When an individual was engaging in suicidal behaviour a cultural interpretation of this behaviour was also made and culturally appropriate treatments sought differences between the Western treatment of depression (e.g. medication, counselling, hospitalisation) and Aboriginal treatments (methods to build resilience against the spirits and to increase wellness). They believed that a blend of the Western and Aboriginal models of mental health intervention would offer a more successful way of intervening with Aboriginal clients experiencing depression (e.g. strategies to assist depressed individuals in developing resilience against the harmful spirits) (Vicary and Westerman, 2004).

Shame is a powerful emotion, profoundly affecting Aboriginal health and health care outcomes and perhaps the most complex and sensitive Aboriginal concept and practice to deal with in a health setting (Morgan, 1997). For Aboriginal people, shame embodies knowledge and emotions associated with situations in which a person is singled out from the group, for either praise or punishment, or with the respect one has for parents, elders, sacred places. Novelty of experience is also another factor which

often leads to the discomfort expressed as 'being shame' by Aboriginal people. For Anglo-Australian participants, the word *shame* is largely associated with 'wrong-doing' and 'feeling of guilt' (Stiarifian, 2004), which can lead to significant misunderstanding.

Cultural conceptualisations of family, which underpin Aboriginal behaviours, thinking, and speaking, 'when people talk about being Aboriginal, they invariably talk about Aboriginal family relationships' (Eades, 1988 cited in Stiarifian, 2004). It is the company of the extended family that gives significance to an event, not the place of the event or even the event itself. Aboriginal people often refer to localities and suburbs in terms of which family and 'mob' resides in them rather than where they are located in relation to the river, the city centre, or other suburbs.

Stiarifian's (2004) study of Aboriginal children in Perth highlights that for many Aboriginal children, family is the centre of existence; everything and everyone is about family and every experience ends in family. This Aboriginal conceptualisation of family relates to issues of guardianship and responsibility, in that one's extended family may share the guardianship of children.

The use by Aboriginal young people of Standard Australian English and Aboriginal languages and dialects is another area where there may be implications for service provision, just as there are in educational settings.

Conceptualisations influence language. For example, Standard Australian English focuses on discrete things whilst Aboriginal languages are contextual and focus on the interconnectedness of things (Morgan, 1997). Teachers and educational systems have tended to make certain assumptions about the linguistic repertoire of Aboriginal students at school. Everything from the learning materials to the tests used at school widely reflects this assumption. Code-switching in educational contexts is well known; educators are provided with practices and strategies for addressing this in schools. These are areas to investigate further in primary health care settings in regard to communication and mental health assessments.

Health interventions are most effective when they are based on Indigenous concepts of holistic health, mental health and social and emotional wellbeing; enhance self-determination and control through strong community leadership and governance; and foster connectedness to country, culture and identity to build on Indigenous strengths, enhance resilience and promote cultural continuity (AIHW, 2014). There is a need for understanding that mental health be considered in a social and emotional context that encompasses the effects of colonisation, oppression, racism, environment, economic factors, stress, trauma, grief, cultural genocide, psychological processes and ill health.





The *Gayaa Dhuwi* (Proud Spirit) Declaration provides Principles of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land and sea, is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill-health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. 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, (versus mental ill-health). Human rights relevant to mental illness must be specifically addressed.
6. 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.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that 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 current policy context in Western Australia in the WA Aboriginal Health and Wellbeing Framework 2015–2030 outlines guiding principles based on Aboriginal community consultation and available evidence. They are designed to underpin system responses and Aboriginal health policies, strategies and programs in Western Australia. These are: cultural security, the health and wellbeing of Aboriginal people is everybody's business, partnerships, Aboriginal community control and engagement, access and equality, and accountability (Department of Health, 2015).

Existing research is limited by the lack of validated psychological assessment tools. This is being addressed through a national initiative to develop and test tools for measuring Social and Emotional Wellbeing amongst Indigenous Australians and the dissemination of recent validation studies on tools used to measure Indigenous mental health (Primary Health Care Research and Information Service, 2012).

The Social and Emotional Wellbeing and Mental Health Services in Aboriginal Australia (2017) has developed culturally specific screening tools:

- Indigenous Risk Impact Screen and Brief Intervention (IRIS)
- Strong Souls: development and validation of a culturally appropriate tool for assessment of social and emotional wellbeing in Indigenous youth
- Westerman Aboriginal Symptom Checklist - Youth (WASC-Y)

## Help seeking

Data about the help seeking behaviour of Australian young people is informed by the 2015 Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing and the 2016 Mission Australia Youth Survey. The most common form of help seeking is informal with the most common sources being friends, family, parents. This remains consistent over time with researchers reporting this finding over the past few decades.

According to Farrelly (2008) help-seeking is categorised as either formal help-seeking which involves services and professionals who have been formally trained as help sources, such as counsellors, psychologists and general practitioners, or informal help seeking which involves untrained help sources, such as family, friends or other community members. The act of help-seeking is said to have three stages: i) problem recognition, ii) belief that external help is needed, and iii) initiated contact with a help source. Stage one is often the most fundamental hurdle for young people to overcome, particularly Indigenous young people, where it relates to mental health concerns (Price & Dalgleish, 2013).

## Formal help seeking

In Australia, engaging young people with the services available is a challenge; only 13% of young men and 31% of young women seek professional assistance (Slade, 2009). Formal help seeking tends to be used more by young people with a diagnosed mental disorder compared to the general population of young people.

According to Lawrence et al (2015), among all adolescents, 3.4% had either been in contact with a health professional by telephone or online (1.6%) or had visited a headspace centre (2.8%). A larger proportion of 13-17 year olds had accessed information via the headspace or eheadspace websites (5.7%). More females than males had accessed headspace services (10.2% versus 4.8%) largely due to higher proportions accessing information on the websites.

For adolescents with mental disorders, one fifth (20.2%) of 13-17 year-olds with major depressive disorder reported using a service provided by headspace, with the majority of these accessing information on the headspace website or through eheadspace (14.8%). One twelfth (8.5%) spoke to a mental health professional on the telephone or received online support, and 11% visited a headspace centre.



Sense of efficacy and trust

Concerns around trust, confidentiality and anonymity are frequently reported by hard to reach young people as barriers to accessing treatment. Indigenous young people are more likely to engage in indirect help-seeking (e.g. a general yarn, information seeking, joke telling) than direct help-seeking (i.e. counselling), representing 4.0% and 2.5% of all contacts respectively. The more informal, indirect interaction is thought to be particularly important to this cultural group as it allows for initial exploration of the service’s trustworthiness and cultural competence (Price & Dalgleish, 2013).

In 2014–15, one-third (33%) of Aboriginal and Torres Strait Islander people aged 15 years and over agreed that most people can be trusted. The majority (81%) agreed that their own doctor could be trusted, 65% that hospitals could be trusted, and 58% that local police could be trusted (ABS, 2016).

Informal help seeking

Many young people seek informal help from family or peers. For all adolescents, 13-17 year-olds, Lawrence et al (2015), report nearly two thirds 62.9% had received informal help or support for emotional or behavioural problems in the previous 12 months. For those young people without mental disorders, more than half (57.9%) had received informal support or help for emotional or behavioural problems in the previous 12 months. This proportion was higher among females than males (74.3% compared with 52.1%) and higher for adolescents with major depressive disorders (93.9%) or with mental disorders (80.3%).

The 2016 Mission Australia Survey and the 2015 Mental Health of Children and Adolescents Survey report similar ranking for sources of informal health seeking with friends, parents and relatives as the highest. There was a difference in proportion depending whether the young person had a mental disorder or no disorder. For all adolescents, most commonly young people received informal help or support from a friend (48.5%), a parent (46.1%), a boyfriend or girlfriend (32.7%), a teacher (16.7%), or another school staff member, such as a counsellor or nurse (13.1%).

By comparison, adolescents with major depressive disorders sought informal help or support from a friend (78.5%), a parent (64.1%), a teacher (28.7%), or another school staff member, such as a counsellor or nurse (35.8%) (Lawrence et al., 2015).

Table 1: Informal help or support received for emotional or behavioural problems in past 12 months among 13-17 year olds by mental health status

Source of informal help or suport	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)	No disorder
Parent	64	67	42
Brother or sister	37	34	23
Other family member	31	30	17
Boyfriend or girlfriend	67	45	27
Friend	79	57	45
Teacher	29	24	15
Other school staff	36	28	9
Other unrelated adult	31	31	13
Any informal support	94	80	58

Source: Lawrence et al., 2015

According to the 2016 Mission Australia Youth Survey, the top three sources of help for young people, were friends (74.8% ATSI compared with 83.4% non-ATSI), parents (69.1% ATSI compared with 76.6% non-ATSI) and relatives/family friends(64.1% compared with 61.2%). Other informal sources include brother/sister (56.0% compared with 51.8% of non ATSI), internet (39.3% compared with 46.4%), teacher (35.9% compared with 36.1%), school counsellor (31.2%; similar for both), online counselling website/s (16.5% compared with 15.7%), and community agency (16.6% of ATSI young people compared with 8.5% non ATSI young people) (Bailey et al., 2016).

Perceived need for help

Low perceived need for help is one of the most common reasons for not initiating treatment and possibly the reason why informal help seeking is much more common than formal help seeking. There was some discrepancy in the literature regarding whether low perceived need was more common among people with mild, moderate or severe disorders.

Andrade et al. (2014) reviewed data from 24 countries (Australia was not among them) and found that low perceived need for treatment is an extremely important barrier for seeking treatment. Low perceived need was reported at similar rates between respondents with serious disorders and those with moderate/mild disorders.

Lawrence et al. (2015) report that four fifths of adolescents with major depressive disorder (82.4%) reported a need for one or more types of help for emotional or behavioural problems in the previous 12 months. The extent to which 13-17 year-olds reported a perceived need for help with their emotional or behavioural problems increased with severity of disorder. Those with moderate and severe disorders had greater perceived need than those with mild disorders. For adolescents identified as having a severe or moderate major depressive disorder, most indicated that they had a need for help with emotional and behavioural problems (90.7% and 94.8% respectively). A lower proportion (65.4%) of those with mild depressive disorder felt that they had a need for some type of help.

Type of help needed

Lawrence et al. (2015) reports on four types of help needed with emotional or behavioural problems expressed by 13 - 17 year olds. More than half of adolescents with major depressive disorder (55.9%) say they want information about emotional or behavioural problems, treatment and available services and 51.5% state that they want courses or other counselling for life skills, self-esteem or motivation. Adolescents with major depressive disorder (44.2%) say they want prescribed medication for emotional or behavioural problems but the most common type of help they felt that they needed in the previous 12 months was counselling or a talking therapy (68.8%) either one-on-one, as a family, or in a group.

Around nine in ten (87.9%) adolescents with a severe major depressive disorder who reported some type of need for help indicated that their needs were either fully (24.9%) or partially (63.0%) met. Lower rates of fully or partially met need were reported by adolescents with moderate (69.4%) and mild depressive disorders (70.2%).



## Online service and help

The way in which young people use and engage with technologies has substantially shifted with the introduction of smart devices, faster Internet speeds, and improved accessibility. There is acceptance of the importance of the Internet as a setting in which young people spend time, interact and seek help for mental health concerns.

Technologies could provide an important adjunct to support traditional forms of clinical engagement and/or act as a support platform enabling professionals to interact via the Internet. Burns et al (2010), found that 21% of 12-17 year olds and 34% of 18-25 year olds reported they had searched online for support.

Van Dyke et al (2014) reports that the most popular websites accessed by WA young people were Reach Out and Safe Sex No Regrets with almost all of the ‘other’ sites mentioned being beyondblue or headspace. The most common reason for doing so was to get health information. Health websites accessed were predominantly deemed to be ‘somewhat helpful’ and ‘very helpful’ by the young people.

Lawrence et al. (2015) report on the use of telephone helplines such as Kids Helpline and online services including services provided by headspace, Reachout and Youth beyondblue for emotional and behavioural problems. Of all 13-17 year-olds, 3.6% reported using a telephone counselling line for help or information and 22.2% had used an online service. Among young people with a major depressive disorder, 13.6% had used a telephone counselling service and 52% had used an online service. The way online services were used differed between young people with major depressive disorder and those with no disorder; 40.2% compared to 11.5% used the Internet to find information about mental health issues; 29.6% compared to 8.0% used the Internet for online assessment tools. Among young people with a major depressive disorder, 8.6%, participated in a chat room or support group, 7.4% received online personal support or counselling and 14.8% used the Internet for self-help.

Data from Australia’s 24/7 youth counselling service, Kids Helpline, show that 3% of the 42,151 contacts to the service in 2011 were from Indigenous young people. In comparison, Indigenous young people represent 4.1% of all Australians aged 15-24 (Australian Bureau of Statistics, 2017). Interestingly, Indigenous young people appear more likely to contact Kids Helpline for indirect help-seeking (e.g. a general yarn, information seeking, joke telling) than direct help-seeking (i.e. counselling) representing 4% and 2.5% of all contacts respectively. As mentioned previously, informal, indirect interactions are thought to be particularly important to this cultural group as it allows for initial exploration of the service’s trustworthiness and cultural competence (Price & Dalglish, 2013).

Online interventions and clinical services provided over the Internet can potentially offer greater reach with the capacity to provide an anonymous entryway to care. Further investigation of the facilitators and barriers to Internet based services, provided within an integrated system of care, are worthy of further investigation, particularly for rural and remote young people.

## Barriers and facilitators of help seeking

There is a considerable body of literature about barriers and enablers for young people seeking help. Common barriers impeding help-seeking can be categorised as personal and interpersonal including lack of emotional competence, negative attitudes toward professional help-seeking, embarrassment, preference for self-reliance, fear of stigma, confidentiality concerns, racism, prior negative experiences, perceived ineffectiveness of treatment, and fear needs won’t be met (Rickwood et al., 2005; Andrade, 2014; Brown et al., 2016).

In Hilferty et al. (2015), interviewees identified the mental and cognitive functioning of clients as a barrier to access and sustained engagement with headspace services. Being too scared to talk face-to-face to a counsellor leading to reluctance to attend a centre was reported by a number of young people. Given that many of the young people who attend the service are dealing with crippling anxiety issues, making initial contact was often described as a huge challenge.

Andrade et al. (2014) describe attitudinal factors, ‘wanting to handle on own’, ‘perceived ineffectiveness of treatment’ and ‘low perceived need’ and structural factors, such as transport and financial reasons. Attitudinal reasons were the most reported reasons with the most commonly given reason ‘wanting to handle it on own’ and secondly ‘belief that the problems was not severe and would get better on own’.

Structural barriers were rarely reported as the reason for not seeking help or for dropping out of treatment. This is reinforced by Hilferty et al. (2015) who list ‘distance from a centre’, ‘centre opening hours’ and ‘lack of transport’ and ‘wait times for service’ as reasons why young people don’t engage with a headspace. However, this statement from a male, 18 year old respondent reinforces the prevalence of attitudinal barriers, *“the problem is themselves. It’s the going out and seeking help and wanting to get better. The problem is more to do with that than problems with the actual centre”*.

Lannin et al. (2015) argues that self stigmatising labels of being insecure, inferior and weak reduce a persons’ intention to seek counselling because it erodes positive attitude to counselling. He concludes that there is wasted effort in psychoeducation interventions if we don’t mitigate

the threat of self stigma. Self affirmation theory is a possible approach to overcome this which highlights positive self perceptions prior to an education of intervention.

In their review of at risk young people, Brown et al. (2016) list barriers as knowledge factors including poor mental health literacy, lack of knowledge about where to seek help and treatment and service factors such as confidentiality, trust, need for anonymity, and lack of support from others for treatment.

Lawrence et al. (2015) report the most commonly identified reasons given by 13-17 year-olds with major depressive disorder for not seeking help or receiving more help for emotional or behavioural problems were being worried about what other people might think or not wanting to talk to a stranger (62.9%), thinking the problem would get better by itself (61.7%) and wanting to work out the problem on their own or with help from family or friends (57.1%). Among adolescents with mental disorders the most common reasons cited for not seeking help or receiving more help were similar to those with major depressive disorder but proportions identifying these reasons were lower for most categories.

For those who dropped out of treatment, the top responses were ‘wanting to handle on own’ and ‘perceived ineffectiveness of treatment’. Andrade et al. (2014) raises some possible explanations such as mental health literacy, cultural perceptions and stigma, and label avoidance. ‘Negative experience’ was reported more by those with severe mental illness compared to mild or moderate with reasons given for this being rejection of the passive nature of the patient role and the pharmacological versus counselling treatment that may be offered by primary care professionals due to time constraints.

Specific barriers to Indigenous young people seeking help include ‘concerns regarding confidentiality, trust and judgement’, ‘intense fears of shame, social ostracism and intervention’, ‘limited access to private internet (and limited internet literacy)’, and ‘service’s lack of cultural competence’ (Price & Dalglish, 2013). In addition, Brown et al. (2016) mentions poor service knowledge and reliance on informal supports.

Rickwood et al. (2005) offers implications for interventions to encourage young people’s help-seeking, which are:

- Young people need to be encouraged to actively build supportive relationships.
- Professional help-seeking services need to be taken to young people.
- Mental health service providers for young people operate within a recovery orientation.
- Avenues of mental health support need to be facilitated for young people to counteract feeling hopelessness and withdrawal.
- Support the development of emotional competence.
- Building mental health literacy.
- Framing help-seeking as an important life skill that needs to be learned, mastered and used as needed, rather than evidence of weakness.

Price and Dalglish (2013) offer specific strategies to facilitate help seeking and generate positive help-seeking experiences for Aboriginal young people, many of which are consistent with strategies for all young people.

- Engage young people in education strategies to help inform expectations what service offers, service pathways, increase awareness of the service’s email and web counselling capabilities, and provide a sense of hope that seeking formal help can be of assistance.
- Reduce common negative perceptions related to formal help-seeking; concerns relating to quality, trust, confidentiality, judgment and shame.
- Recognising the value of “yarning” and encouraging its practice.
- Allowing young people to trial the service in a supported group environment to provide an opportunity for increasing familiarity.
- Providing young people with case studies and/or engaging known help-seeking peers to act as advocates.
- Staging school-based liaisons over numerous visits may assist retention and rapport building.
- “Private” modalities such as mobile conversation. Strategies that enable a service’s number to be listed as unidentifiable on all mobile and landline bills.
- Developing culturally appropriate marketing collateral.



## Engagement of hard to reach young people

The literature deals with access, engagement and help seeking, sometimes as separate concepts and other times links the concepts, facilitators and barriers together. This makes it somewhat challenging to differentiate between three ideas. This section attempts to treat them as separate concepts; however there are times when engagement and access are combined.

Access to services and mental health care are often described within the parameters of availability, affordability, awareness and equity of services (Tylee et al., 2007) whilst the engagement of a young person into mental health care is defined as a process of enlisting an individual into a therapy, with the length of time variable between individuals. The process itself is fundamental to mental health outcomes (French et al., 2003). In parts of Australia, young people now have access to youth specific primary mental health care with the emergence of headspace services which intended to overcome some of the barriers to access reported previously.

There is considerable literature outlining features needed by services to be more accessible to young people. The literature is clear on the factors that facilitate and hinder young people and Aboriginal young people accessing and engaging with services and programs at a community and individual level. The Closing the Gap Clearinghouse has numerous research papers documenting what does and doesn't work in the areas of access to health services and engagement in programs and services for Aboriginal people. There is evidence that both mainstream and Indigenous-specific programs and services that adhere to the Closing the Gap service-delivery principles of engagement, access, integration and accountability are more effective than those that do not (AIHW, 2014).

### Service use

Young people do not generally identify with the term, 'health services', rather they refer to individual services, such as their GP or school nurse. Young people's knowledge of health services is largely based on those health services they have attended and most often parents rather than the young person choose a health service and accompany them to appointments (Van Dyke et al., 2014).

There is agreement in the literature that adolescents with mental health problems access health services much less frequently than other young people. Young people from CaLD and refugee backgrounds have a higher risk of mental health problems and face additional barriers to accessing services. Young people with a range of disabilities or chronic illness are at higher risk of developing mental health problems than other young people.

Primary Health Care Research & Information Service (PHCRIS) (2012) reports that only a small proportion of at-risk youth had contact with mental health services, including 3.8 % of children aged 4-11 years and 11% of children aged 12-17 years.

Not only are Aboriginal young people less likely than their non Aboriginal counterparts to engage in mental health services, they are also likely to engage at a more chronic level, and do so for shorter periods of time (Westerman 2010) and are over-represented in inpatient mental health care (Berry & Crowe, 2009). When Aboriginal people do come into contact with mental health services they are more likely to receive services which are primarily reactive in their nature (Westerman, 2010). Services were often not made available to young people until a major problem, such as an arrest, had already occurred. Indigenous young people comprise 3.7% of the youth population nationally but make up 7.4% of headspace clients (Hilferty et al., 2015).

### Aboriginal young people's engagement with services and programs

Engagement is not 'consultation'. It is an ongoing process or conversation that builds trust and relationships and is seen as an interaction between groups of people working towards shared goals. There needs to be honesty about the nature of the engagement, opportunities for a diverse range of opinions to be expressed, time for deliberation, and for the people involved to actually have influence over how they will participate and the outcomes determined.

Westerman (2010) argues that there is a lack of empirically grounded conceptual frameworks that have proven their efficacy with Aboriginal youth. The historical approach has been to adjust mainstream services to Aboriginal people rather than building empirically sound service frameworks for Aboriginal people.

There are a range of problems that impact on the engagement of Aboriginal young people in mental health services that can be identified at either the practitioner level or the system level of service delivery. In a study conducted by Wright et al (2013), Aboriginal respondents were clear that mental health service providers needed to significantly improve their relationships and engagement with the local Nyoongar community at an organizational systems level and at the client-practitioner (clinical) level.

The most cited reason for Aboriginal people not engaging with programs or services is the 'cultural inappropriateness' of existing services or the failure of mental health services and clinicians to embrace Aboriginal conceptualisations of health and well-being (AIHW, 2014).

Reluctance or inability to contact mental health services may be due to many factors including remoteness, language barriers, affordability and cultural sensitivity issues (PHCRIS, 2012). A major theme for Aboriginal families' reluctance to access mental health services, either for young people or their carers, is fear of government authorities becoming involved and children being removed (Williamson, 2010).

### Facilitators of engagement

This section outlines facilitators and barriers to access and engagement for young people which are presented at the practitioner level and the system or service level. Whilst there are a range of factors from the literature, the most prominent issues are confidentiality and trust and being treated respectfully.

The degree that each factor or combination of factors encourage hard to reach young people to access and engage with a mental health service are not described, however, it is accepted that a multi pronged approach and strategies to change services is required.





### Facilitators of engagement at the practitioner level

Adolescence is a time of personal and interpersonal change where emotional competence is often not developed and where embarrassment, fear of stigma, and confidentiality concerns are high. Young people report the need for youth friendly staff to establish a relationship, be respectful and listen to young people’s concerns and acknowledge their rights.

Some subpopulation groups experience specific factors that impact on their access to health services, particularly homeless, Aboriginal, CaLD, and LGBTI young people, and young carers. Authentic engagement, trusting relationships and communication are important issues in conjunction with cultural appropriateness.

Westerman (2010) states there have been few attempts fully operationalise cultural appropriateness or give strategies for clinicians to adapt their practice appropriately and that it is necessary for practitioners to have both cultural competencies and clinical competencies.

For LGBTI young people, Australian research shows that approximately 23 per cent perceive that health professionals are homophobic, support heterosexuality, lack knowledge , misunderstand LGBTI young people, have turned young people away, lack regard for patient confidentiality, or lack relevant psycho-sexual training (Van Dyke et al., 2014).

There can be problems related to clinicians having a lack of cultural knowledge, understanding of local customs, language and norms, and the cultural appropriateness of the processes used by practitioners when engaging with Aboriginal young people in a client relationship. Cultural respectfulness can be enhanced by introductions between clinicians and clients which incorporate understandings of the land and familial relationships; the assessment of Indigenous clients within their own cultural context; acknowledging Indigenous concepts of mental health as holistic; and the use of cultural consultants as a first step in engaging Indigenous clients (Westerman, 2003).

Young carers also feel that professionals in fields of health, welfare and education are often unaware of a carer’s unique and diverse needs of children and young people who have caring responsibilities and diverse needs or how to meet them.

Communication style has been found to be very important when engaging Indigenous clients. Direct questioning is considered by many Indigenous people to be an ill-mannered and inappropriate way to begin a relationship, and the older and more respected the person is, the more inappropriate direct questioning may be. A style that doesn’t put pressure on people by demanding a direct answer may be more appropriate for Indigenous clients (Berry & Crowe, 2009). Some clients may prefer for a therapist to develop a broader relationship with them, rather than the traditional separation of the professional and personal domains (Vicary & Westerman, 2004).

The psychotherapy process has been found to be problematic when working in Indigenous communities due to the high level of self disclosure required, and the intrusive nature of the therapeutic experience (Berry & Crowe, 2009). The best therapeutic approach involves a narrative style of communication, including open-ended questions which are positively-phrased.

Westerman (2004) has developed a Model of Engagement for Aboriginal youth in Western Australia. This model includes:

- 1. Consider the location of therapy
- 2. Sit or stand ‘side by side’ with clients
- 3. Notice and acknowledge any non-verbal expression of illness or discomfort
- 4. Make a statement about any cultural or gender differences
- 5. If these differences are seen as an issue, ask client to nominate cultural consultant.

Conditions for authentic engagement at a staff level are described in Wright (2015) *Minditj Kaart-Moorditj Kaart: A comprehensive framework for systems change in service delivery*. These conditions are: respect status, be motivated, be present, be committed, be teachable, stay connected and continual weaving.

### Facilitators of engagement at the system level

Reported factors that facilitate engagement for young people at headspace centres were the youth-friendly environment, staff that are friendly, non-judgemental and that ‘click’ with you, and the free or low cost service, which are largely at the practitioner level. Staff and service providers reported having a wide range of services and innovative modes of engagement as service level factors that facilitate engagement (Hilferty et al., 2015). Other system level facilitating factors reported by young people include having their own Medicare cards, accessible transport, housing, doctors who provide bulk-billing, flexible appointment times, services offered free or at low cost, drop in youth centres and one-stop shops, and outreach services.

The literature describes service level strategies to enhance successful engagement with Aboriginal young people and other subgroups of young people. Long-term relationships of trust, respect and honesty as well as accessible, ongoing communication and information is fundamental. This trust at a system level may refer to flexible projects designed in consultation, engagement and partnership with the community and cultural competency to respond to Indigenous history, cultures and diversity of Indigenous communities (AIHW, 2013, 2014).

Wright, M., O’Connell, M., and Jones, T (2013) describe in detail a system change model naming conditions for engagement whereby services review their organizational structure across the areas of governance, management/ leadership, workforce, resourcing, communication and work ethos/culture. Secondly, a team-based review of a service’s clinical practices is described and involves a set of four inclusive working practices which are: everyone as partners, building trust, common language for shared understanding, and tolerance of uncertainty.

Specific service and system strategies suggested within the literature for the mainstream sector include embracing the research evidence therefore reducing systemic racism, lack of cultural understanding and appropriateness, and a reliance on ‘one size fits all’ approaches (AIHW, 2014) and being culturally-sensitive for delivery and location of services (i.e. not adjacent to a child welfare office). Recommendations also include the involvement of Indigenous workers across all sectors (Williamson, 2010) and the use of cultural consultants as standard practice for clinicians working with Indigenous populations (Westerman, 2004). The consultant is an Indigenous who can ‘vouch’ for the non-Indigenous practitioner, and can act as the first point of contact between the clinician and the client.

In an independent evaluation of the headspace program, Hilferty et al. (2015) report that despite an overrepresentation of Aboriginal young people attending (compared to the overall population of Aboriginal young people), headspace centres could do more to make the service more culturally appropriate for Indigenous clients. Criticisms were concerned with staffing, particularly the absence of Aboriginal workers and the centre-based service model, which did not meet the needs of Indigenous young people (attending at a scheduled time rather than having flexibility so that when things arise there’s somebody there to talk to, not having to book in an appointment a week later).

Evaluation data suggests that engagement with more marginalised groups will require partnerships with community organisations, as well as ongoing relationship building activities that include local community members and leaders. Further research may be required to determine if specific Indigenous and CaLD workforce development, as well as changes to treatment practices (such as provision of outreach services, and/or increased capacity to see those that drop in to centres without a pre-arranged appointment) would improve the engagement and outcomes of these highly vulnerable young people. Universal health prevention strategies that preserve anonymity have been shown to increase youth access and participation (Van Dyke et al., 2014).



## Service delivery approaches and strategies

There is a need to provide more flexible services that do not follow a rigid, place-based, time allocated, clinical model, but rather a non-threatening model based on the needs and lives of young people. A different approach is required, however, given the pressures of work in this sector and staff often feel isolated, unsupported and needing to rapidly deliver over short timeframes the enactment of these ideas is restricted.

### Participation and engagement for mental health promoting effects

Burns and Birrell (2014) state that youth participation is the cornerstone to mental health promotion with social inclusion, sense of belonging and connectedness being core protective factors. This is what youth participation and

engagement does. Therefore, a service model needs to engage with young people for input into decision making and because it will help engage young people in the service but also because their participation can promote positive mental health in and of itself.

Emerging research is beginning to paint a picture of the important role of youth participation in promoting the mental health and well-being of young people. Berry and Crowe (2009) found that increased levels of participation in particular activities of randomly selected participants from a New South Wales coastal town in Australia correlated with lower levels of psychological distress. While the importance of youth participation for health promotion is well-argued in the literature, some fundamental areas of research in this area to date remain largely unexplored (Burns & Birrell, 2014).



### Culturally appropriate services

The history of limited program success in Indigenous mental health and social and emotional wellbeing can be linked to a number of factors, including a 'one size fits all' approach; insufficient and ad hoc funding and rigid funding arrangements; lack of skilled staff; expectations of long-term outcomes being achieved within short timeframes; poorly coordinated and monitored programs and services; multiple and burdensome accountability requirements; and a lack of proper engagement and partnership with community-based organisations (CREAHW 2009; AIHW, 2014).

Despite the widespread publication and policy directions and principles of working with Aboriginal people, the implementation of these philosophical ways of working and using empirically validated assessment tools and therapeutic approaches are less well known. Of the limited number of programs targeted specifically to Indigenous youth, even fewer have been evaluated, possibly due to funding constraints or the paucity of validated tools for measuring social and emotional wellbeing in these populations (PHCRIS, 2012).

There is evidence that programs that are developed or implemented in accordance with the guiding principles adopted by the *Gayaa Dhuwi* (Proud Spirit) Declaration, described earlier, are more likely to be effective and have positive outcomes than those that do not. They were first proposed in the Ways Forward Report (Swan & Raphael, 1995), and they acknowledge the critical importance of Indigenous Australians' cultural values.

A review of 49 studies describing 42 programs or initiatives highlighted a number of common, interrelated themes for program and service delivery success (AIHW, 2014). The most effective programs were those that focused on both process and outcomes. Many of these program evaluation findings emphasised the need for Indigenous participation in the design and delivery and evaluation of programs. Participatory Action Research methods were used as an effective mechanism for involving Indigenous families and communities in developing programs that were culturally responsive to local contexts.

The Looking Forward Aboriginal Mental Health Project that aimed at increasing access to and responsiveness of the mental health and drug and alcohol system for Nyoongar families in south east metropolitan Perth (Wright, 2015) used both Participatory Action Research and Indigenous Research frameworks as both approaches are committed to empowering participants to address power imbalances.

The Family Wellbeing Program (FWP), initially started in South Australia and modified and adapted in Queensland and other places, is an exemplar of comprehensive programs that focuses on enhancing people's sense of empowerment and control over their lives, as well as a community's collective esteem, efficacy, control and self-determination (AIHW, 2014). The FWP uses Participatory Action Research and community capacity building over the long term to empower people to gain greater control over their lives and situations and skills to make and sustain healthier lives.

To work collaboratively with Indigenous services and the community, enabling strong Indigenous community control and ownership, building community partnerships and networks, and building relationships and trust were seen as pivotal principles in the process of effective collaboration (Wright, 2013). Findings from the Looking Forward Aboriginal Mental Health Project show that Nyoongar people are seeking greater collaboration in the way mental health and drug and alcohol services are provided. They are keen for organizations to work with them; to recognize their collective wisdom and expertise, and to acknowledge them as partners in the design of their health care plans.

Commitment to being, and demonstrating, culturally appropriateness, competent and respectful of Indigenous culture is vital. This can translate to valuing Indigenous involvement, ensuring staff are appropriately trained, promoting cultural continuity and renewal, focusing on effective communication, and engaging in activities that promote pride and identity (AIHW, 2014; PHCRIS, 2012). Cultural respectfulness (cultural safety) of services is evident in such things as preparedness to engage family and Indigenous workers beyond tokenism (Berry & Crowe, 2009). Wright (2015) has dispensed with the phrase 'cultural safety', stating that it is fraught with misunderstanding and that over time the term has become meaningless, because it is





applied as a blanket concept that does not take into account existing cultural diversity across and within Aboriginal groups in Australia. The Nyoongar community would prefer mental health services to be delivered in a way that demonstrates a comprehensive understanding and respect for a Nyoongar worldview, incorporating its protocols, practices and cultural contexts and as such the project developed a comprehensive framework for systems change in service delivery.

Other recommended strategies include a strong capacity building focus, where knowledge, resources and skills are shared and developed and Indigenous experience and knowledge is recognised; enhancing existing services ; working together with mainstream and Indigenous services to support the delivery of a holistic and integrated program or service; and flexibility, having structures and components that cater to local need.

A fundamental concept for service delivery that fits with Australian Aboriginal cultural conceptualisations is that of focussing on the family and community and not the individual. There is a vast body of international literature regarding First Nation peoples’ conceptualisations of health and how to support mental health, which is consistent with Aboriginal communities in Australia. First Nations cultures in Canada lean more towards collectivism than individualism and this has important implications for the nature of the solutions developed (Mussell, 2004). Individualistic approaches are not highly relevant or effective in Indigenous communities in Canada. Given the existence of large extended family networks within First Nations

communities and the frequent occurrence of complex multi-generational family issues large-scale holistic or ecological interventions are needed. It is not expected that individually focused models of treatment, such as behavioural therapy, will bring about sustainable change in environments with complex, interdependent relationships.

Australian literature is heavily weighted in this concept, from Closing the Gap publications stating repeatedly that, an ongoing silo mentality around mental health and wellbeing policy formulation, as well as in the implementation of programs, service delivery and practice, sees efforts being primarily focused on the individual, with limited regard for family or community contexts (AIHW, 2014).

Williamson et al. (2010) found that strong family connections and support were seen as the foundation of good social and emotional wellbeing among Aboriginal young people, while family problems were thought to be the primary cause of most difficulties. The importance of a young person’s relationship to family was demonstrated by many participants stating that it would be impossible to accurately assess the mental health of an Aboriginal young person without observing his or her interaction with relatives.

Recent Australian data supports this premise with the majority of Aboriginal and Torres Strait Islander people aged 15 years and over having had face-to-face contact with family or friends at least once a week. People in remote areas were more likely than those in non-remote areas to have had daily face-to-face contact (66% compared to 37%); a possible reflection of the relatively close proximity to family and friends in discrete

Aboriginal and Torres Strait Islander communities, in which the sense of a single community may be stronger than the concept of separate households (ABS, 2016).

Family and community support is also strong with the majority (92%) of Aboriginal and Torres Strait Islander people aged 15 years and over having said they were able to get support from outside their household in a time of crisis. In addition, 82% of Aboriginal and Torres Strait Islander people aged 15 years and over said they were able to confide in family or friends living outside their household. Aboriginal and Torres Strait Islander people in non-remote areas were more likely than those in remote areas to say they have family and/or friends outside the household in whom they could confide (87% compared with 65%) (ABS, 2016).

Burns and Birrell (2014) suggest social determinants theory used in the World Health Organization approach to mental health promotion and prevention moves beyond a disease-focused model to one that encompassed individual and societal issues collectively, with a focus on well-being. This approach makes links with Aboriginal concepts of health as holistic.

## Supporting young people

There are a number of publications that have reviewed programs and services providing mental health support to at risk and Aboriginal young people. Key principles for service delivery have been reported earlier. It has been stated that there is a lack of empirically grounded conceptual frameworks that have proven their efficacy with Aboriginal young people and there have not been many well evaluated programs and services (Westerman, 2010; AIHW, 2015; Dudgeon et al., 2014; PHCRIS, 2012). The National Mental Health Commission *National Report Card on Mental Health Services and Suicide Prevention* stated that there is ‘surprisingly little evidence about what works in suicide prevention’. Of the 27 suicide prevention programmes operating in Aboriginal and Torres Strait Islander communities, none have been formally evaluated.

Whilst it may not be possible to implement interventions based on evaluated programs it is possible to glean emerging best practice from the opinions of experts and those with experience in the field. Below is an outline of a limited number of possible approaches that show promise.

1. In the WA Mental Health, Alcohol and Other Drug Services Plan 2015–2025, feedback from the Pilbara outlined that *school-based education and intervention* should be a priority. The Plan identifies this as a key action by the end of 2017; to identify opportunities to

enhance existing prevention initiatives targeting children, young people, families and the broader community including (but not limited to) school-based programs which incorporate mental health, alcohol and other drug education, and resilience building. By the end of 2020, to rebalance the system there is a need to: complete the rollout of school-based education programs on mental health, alcohol and other drugs, and resilience building until available in all schools(Western Australian Mental Health Commission, 2015).

2. The WA Aboriginal Health and Wellbeing Framework 2015–2030 (Department of Health, 2015) states that through an extensive consultation process, Aboriginal people have said that *cultural, family and community connectedness* is central to their health and wellbeing.

- Community is where we live, support family, maintain our connections to country and culture and go to school and work. These factors are important in developing a strong sense of community. We need to feel safe in our community and know we can find help, including health services close by if we need them. Maintaining and developing the connections between community and services is important in developing healthy communities.” Community health and wellbeing was described as:

- A strong sense of identity, culture, connection to family, community and country.
- Community interaction, supporting each other, having elders to talk to, families making spirits healthy, participating in ceremony and passing on culture.
- Kids playing sport and having access to healthy cooking, good food and bush tucker.
- Aboriginal cultural beliefs and values contribute to the health and wellbeing of Aboriginal people.
- Storytelling, participation in cultural activities and cultural responsibilities through kinships.
- Safe places where people yarn, listen, learn, belong, are happy, friendly and connected. Both physical and spiritual health and inclusive of mind, body and spirit.
- Individual, family and community responsibility, where people are engaged and respectful of the need to be accountable as a collective for Aboriginal health and wellbeing.

3. The *Aboriginal youth mental health partnership* aimed to provide accessible and culturally appropriate mental health services (via a dedicated project worker) for Indigenous youth involved in, or at risk of involvement in, the juvenile justice system. During the three-year



- project duration, the number of Indigenous youth and their families receiving a service from the metropolitan Child and Adolescent Mental Health Services (CAMHS) increased by 44.6%, and there was a 117% increase in the number of Indigenous youth who received a service from the Country Services CAMHS. Overall, there was a 2.4% increase in the number of Indigenous clients receiving a service from CAMHS metropolitan and country services during the project period. The project's success was increased by "Öbuilding trust through networking, being responsive and flexible and becoming known and visible within the Aboriginal community" (Dobson I, Darling K, 2003 as cited in PHCRIS, 2012).
4. As part of the broader *Building bridges: learning from the experts* project, Indigenous youth and prisoners were provided with access to interactive kiosks that included a suicide prevention module *Buluru Yealamucka – Healing Spirit*. The kiosks were seen as a dynamic and sustainable tool for educating Indigenous people about suicide prevention and other important health issues. Overall, the Building bridges project resulted in community changes that enhanced resilience to, and reduced the risk of, self-harm and suicidal behaviours occurring in the community (McKay et al. n.d. as cited in PHCRIS, 2012).

5. *KidsMatter and MindMatters*, as universal mental health promotion and prevention approaches are used in primary and secondary schools in Australia. They involve using multiple strategies that require that all stakeholders, parents, students, staff and the community work together to create a protective environment that promotes mental health and social and emotional wellbeing (Van Dyke et al., 2014). *MindMatters* is a non-Indigenous-specific school-based mental health promotion program. One example of implementation is as a pilot project at an Indigenous school in Queensland, and evaluators considered it a success in terms of the school-related outcomes (professional development; curriculum development). (Sheehan M, Ridge D, Marshall B, 2002). However, it was unclear whether any mental health outcomes were measured or reported in the participants (PHCRIS, 2012).
6. Australian Institute of Health and Welfare (AIHW, 2014), *Closing the Gap Clearinghouse* list a number of projects that show promise working with Aboriginal people.
7. Mussell (2004) The Mental Health and Well-Being of Aboriginal Children and Youth have an annotated bibliography of projects working with Indigenous children and young people in Canada.



8. There is substantial evidence of *promotion and prevention* strategies to improve mental health and reduce mental health problems in universal and targeted programs using a settings approach - schools, workplaces, communities where people gather and live their lives. Programs may use one or a combination of dimensions focussing on general social/emotional cognitive skill building, changing school ecology, multicomponent programmes, and targeted programmes.
10. *In school and out of school programs* that show good evidence and also show promise but have not been evaluated or evaluated to a good standard that conclusions can be drawn from (World Health Organization, 2015).
11. *Education about mental illness* - more effort spent in educating Aboriginal people about mental illness and overcoming the stigma of seeking assistance for such issues. This is particularly the case with depression, which often goes unrecognised and untreated and subsequently may be one of the factors contributing to the high incidence of Aboriginal suicide in Australia. Participants felt that western and Indigenous psychology must work in harmony to provide the most efficacious treatment while simultaneously building resilience in Aboriginal individuals, families and communities (Vicary & Westerman, 2004).
12. *The Australian Mental Health First Aid (MHFA)* training was developed to teach people how to provide initial help to someone developing a mental health problem or in a mental health crisis situation. In 2007 this was further developed into a *Mental Health First Aid for Aboriginal and Torres Strait Islander Program*, which was recently evaluated as being culturally appropriate and acceptable to Indigenous people.

13. Language and Culture - *Engaging in cultural activities* is an indicator of positive cultural identity that is associated with better mental health among Indigenous Australians (AIHW, 2014).  
Almost two-thirds (63%) of Aboriginal and Torres Strait Islander people aged 15 years and over, and 75% of Aboriginal and Torres Strait Islander children aged 4-14 years had been involved in selected cultural events, ceremonies or organisations in the last 12 months. Participation rates were higher in remote areas than in non-remote areas for both age groups - 82% compared with 57% for people aged 15 years and over, and 80% compared with 74% for Aboriginal and Torres Strait Islander children (ABS, 2016).  
Using data from the 2002 National Aboriginal and Torres Strait Islander Survey (NATSIS), Dockery (2009, 2010) finds that stronger attachment to traditional culture is associated with better outcomes for Aboriginal and Torres Strait Islander Australians on a range of 'mainstream' indicators: self-assessed health, educational attainment, employment status, the probability of having been arrested and alcohol abuse. His measure of cultural attachment was based on a single score derived from a factor analysis of the survey questions relating to culture, and heavily weighted toward participation in cultural events (Colquhoun & Michael, 2012).
14. *Non-school activities* are an important avenue for young people to develop non-cognitive skills and build networks and are particularly important for vulnerable young people. Positively, significant proportions of respondents to the Youth Survey 2016 indicated involvement in a range of activities over the past year. Three quarters (75.7%) of young people had been involved in sports (as a participant), 67.0% had been involved in sports (as a spectator) and over half had participated in volunteer work (53.5%) or arts/ cultural/ music activities (52.7%) (Mission Australia, 2016).





## Gaps and emerging issues

This literature review sought to provide an overview of existing literature on youth mental health, with an emphasis on Aboriginal young people, because of the high proportion of Aboriginal young people in the project site (Pilbara, Western Australia), disproportionate rates of mental health problems among Aboriginal young people, and challenges engaging this cohort in support services.

Despite a widely held belief that Indigenous clients are not receiving the mental health services they require, there is only a meagre body of published works that examine therapeutic interventions for Indigenous people. Although examples of good practice do exist, practising clinicians do not know what works and what does not work for Indigenous clients and ‘effective programs need to engage in an open-minded search for intervention and counselling strategies that meet the needs of Indigenous clients’ (Berry & Crowe, 2009 cites Westerman, 2004 and Brady, 2002).

There is general agreement that of the limited number of programs targeted specifically to Indigenous youth, even fewer have been evaluated and the lack of good quality evaluations hinder understanding what works. Areas that are not yet fully understood about Indigenous mental health interventions include (AIHW, 2014):

- The effect on mental health outcomes of culturally appropriate, early intervention programs maintained over the long term.
- The additional costs to health and mental health and wellbeing of not implementing programs in culturally responsive, appropriate and respectful ways.
- The long-term cost effectiveness of Indigenous-specific programs—there have been few program evaluations, and where evaluations have taken place, they have usually been conducted before the long-term effects could be assessed.

- The extent to which Access to Allied Psychological Services (ATAPS) Tier 2 is being delivered in accordance with the objectives and principles developed through the Aboriginal and Torres Strait Islander Mental Health Advisory Group.
- The significance of access barriers for young Indigenous people to web-based and telephone helpline services.

In addition, this literature review has uncovered areas where further research would be useful in designing effective services to young people in regional Australia, including:

- Criteria and good practice examples of service collaboration especially in regional and remote areas and with high staff turnover.
- Examples of programs in cultural settings that may utilise talking therapies.
- Foetal Alcohol Syndrome Disorder (FASD) links to mental health and implications for mental health services.
- Effectiveness of single session or brief interventions as young people often limit their engagement with service providers.
- Code switching and culturally suitable mental health assessments in primary health care settings.
- Facilitators and barriers to Internet based services, provided within an integrated system of care, particularly for rural and remote young people.

## Conclusion

The literature is clear on articulating Aboriginal conceptualisations of social and emotional wellbeing as well as what is needed by the system and services in working with Aboriginal people. Program design and delivery should be guided by The *Gayaa Dhuwi* (Proud Spirit) Declaration, 2015 National Aboriginal and Torres Strait Islander Leadership in Mental Health, which outline nine principles.

Historically mainstream services’ theory and practice is dominated by European ideas and try to overlay some bits of Aboriginal conceptualisations to be culturally appropriate but do not tend to have Aboriginal philosophies at the heart.

Access, engagement and help seeking were explored in the literature and were, at times, difficult to differentiate as the concepts are often used interchangeably. The literature reports engagement factors as either system or service level and practitioner level and discuss strategies required to increase engagement of young people, particularly of Aboriginal young people.

In regard to help seeking, young people overwhelmingly use informal supports for help seeking with friends, family, parents and school staff as the main sources. Common barriers to seeking help are categorised as personal and interpersonal or attitudinal. Important facilitators to help seeking are emotional competence, mental health literacy which encourages positive attitudes toward professional help-seeking, understanding what services can do to help, reducing stigma and confidentiality concerns, and increasing perceived effectiveness of treatment.

Within the literature approaches and strategies for effective service delivery across all populations are consistent for effective practice for working with Aboriginal people. Time and trust are significant factors for success.



The importance of developing long term trusting relationships built over time with service users and service providers is vital as is allowing adequate timeframes in the development, delivery and evaluation of programs that is done in consultation with service users and the engagement and partnership with the community. This is also reflected in the need to set realistic expectations that long term outcomes cannot be achieved within a short term project. In addition, flexible approaches that listen to, and take into account, the needs of each person engaging in the service are more likely to be successful. It is essential that services approach young people’s mental health in a holistic manner and focus on their wellbeing within a broader family and community context.



# References

Allison, S., Bastiampillai, T., Goldney, R. (2016). Australia’s national youth mental health initiative: Is headspace underachieving? *Aust N Z J Psychiatry*, 50(2), 111–112.

Andrade L. H., Alonso J., Mneimneh Z., Wells J. E., Hamzawi A. Al-, Borges G., Bromet E., Bruffaerts R., de Girolamo G., de Graaf R., Florescu S., Gureje O., Hinkov H. R., Hu C., Huang Y., Hwang I., Jin R., Karam E. G., Kovess-Masfety V., Levinson D., Matschinger H., O’Neill S., Posada-Villa J., Sagar R., Sampson N. A., Sasu C., Stein D., Takeshima T., Viana M. C., Xavier M., and Kessler R. C. (2014). Barriers to Mental Health Treatment: Results from the WHO World Mental Health (WMH) Surveys Psychol Med. April 2014; 44(6): 1303–1317. <http://dx.doi:10.1017/S0033291713001943>

Australian Bureau of Statistics (2017). Census of Population and Housing 2016, Canberra.

Australian Bureau of Statistics (2016). National Aboriginal and Torres Strait Islander Social Survey, 2014-15, Cat No. 4714.0.

Australian Bureau of Statistics (2010a). Mental Health of Young People, 2007. Canberra.

Australian Bureau of Statistics (2010b). Suicides, Australia, Cat No. 3309.0, 24/07/12, <http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument> (11/09/17)

Australian Institute of Health and Welfare (AIHW). Closing the Gap Clearinghouse. Retrieved from <http://www.aihw.gov.au/closingthegap/publications/>

Australian Institute of Health and Welfare (AIHW). Closing the Gap Clearinghouse. Hunt, Janet. (2013). Engaging with Indigenous Australia—exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities Issues paper no. 12.

Australian Institute of Health and Welfare (AIHW). Closing the Gap Clearinghouse. (2014). Dudgeon, Pat., Walker, Roz., Scrine, Clair., Shepherd, Carrington., Shepherd, Shepherd, Calma, Tom., Ring, Ian. Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people Issues paper no. 12.

Australian Institute of Health and Welfare (AIHW). Closing the Gap Clearinghouse. (2015). Bainbridge, Roxanne., McCalman, Janya., Clifford, Anton., and Tsey, Komla. (2015). Cultural competency in the delivery of health services for Indigenous people Issues paper no. 13.

Bailey, V., Baker, A-M., Cave, L., Fildes, J., Perrens, B., Plummer, J. and Wearing, A. (2016). Mission Australia’s 2016 Youth Survey Report. Mission Australia.

Berry, S.L. & Crowe, T.P. (2009). A review of engagement of Indigenous Australians within mental health and substance abuse services. Australian e-Journal for the Advancement of Mental Health, 8(1), [www.auseinet.com/journal/vol8iss1/berry.pdf](http://www.auseinet.com/journal/vol8iss1/berry.pdf)

[Brown, A., Rice, S. M., Rickwood, D. J., & Parker, A. G. \(2016\). Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. Asia Pac Psychiatry, 8\(1\), 3-22. http://doi:10.1111/appy.12199](#)

[Burns, J., & Birrell, E. \(2014\). Enhancing early engagement with mental health services by young people. Young and Well Cooperative Research Centre, Psychology Research and Behavior Management.](#)

[Butler, C., \(2012\). Indigenous adolescent mental health: what is the role of primary health care? Issue 24 June 2012, Primary Health Care Research and Information Service \(PHCRIS\).](#)

[Colquhoun, S., & Dockery, A. Michael., \(2012\). The link between Indigenous culture and wellbeing: Qualitative evidence for Australian Aboriginal peoples by Centre for Labour Market Research and School of Economics and Finance Curtin University.](#)

Commonwealth of Australia. (2013). *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Retrieved from <http://www.health.gov.au/natsihp>

Department of Health (2015a). *WA Aboriginal Health and Wellbeing Framework 2015–2030*. Retrieved from <http://ww2.health.wa.gov.au/Improving-WA-Health/About-Aboriginal-Health/WA-Aboriginal-Health-and-Wellbeing-Framework-2015-2030>

Department of Health (2015b). *WA Pilbara Health Profile*. Planning and Evaluation Unit September, Stella Serafino, Campbell Anderson and Nina Waenerberg., WA Country Health Service.

Dudgeon, P., Calma, T., Holland, C., (2014). *What Works in Aboriginal and Torres Strait Islander Suicide Prevention*.

Farrelly, Terri. (2008). The Aboriginal Suicide and Self-harm Help-seeking Quandary [online]. Aboriginal and Islander Health Worker Journal, 32(1): 11-15. Availability: <<http://search.informit.com.au/documentSummary;dn=957994991016599;res=IELIND>> ISSN: 1037-3403. [cited 12 Sep 17]

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231)

French R., Reardon M., Smith P. (2003). Engaging with a mental health service: perspectives of at-risk youth. *Child Adolesc Social Work*, 20, 529–548.

Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi, Y., Ngo, H., Nguyen, H., Wingrove, C. and Katz, I. (2015). *Is headspace making a difference to young people’s lives? Final Report of the independent evaluation of the headspace program*. SPRC Report 08/2015. Sydney: Social Policy Research Centre.

Lannin, D. G., Vogel, D. L., Brenner, R. E., Abraham, W. T., & Heath, P. J. (2015). Does Self-Stigma Reduce the Probability of Seeking Mental Health Information? *Journal of Counseling Psychology*, 63(3).

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., Zubrick, SR. (2015). The Mental Health of Children and Adolescents. Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.

Mission Australia (2016) Youth Survey. <https://www.missionaustralia.com.au>

Morgan, D. L., Slade, M., Morgan, C., M A. (1997). Aboriginal Philosophy and its Impact on Health Care Outcomes. *Australian and New Zealand Journal of Public Health*, 21, 6 ProQuest

Mussell .B., Cardiff, K., White, J., (2004). *The Mental Health and Well-Being of Aboriginal Children and Youth: Guidance for New Approaches and Services*. A Research Report Prepared for the British Columbia Ministry of Children and Family Development. Sal’i’shan Institute.

National Aboriginal and Torres Strait Islander Leadership in Mental Health. *Gayaa Dhuwi (Proud Spirit) Declaration: a companion declaration to the Wharer’s Declaration for use by Aboriginal and Torres Strait Islander peoples*. National Aboriginal and Torres Strait Islander Leadership in Mental Health; 2010. Retrieved from: [http://natsilmh.org.au/sites/default/files/gayaa\\_dhuwi\\_declaration\\_A4.pdf](http://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf).

Price, M. and Dalglish, J., (2013). Help-seeking among Indigenous Australian adolescents - Exploring attitudes, behaviours and barriers, *Youth Studies Australia*, 32(1).

Rickwood D.J., Deane F.P., Wilson C.J. (2007). When and how do young people seek professional help for mental health problems? *Med J Aust*, 187, S35–S39.

Roxbee, L. and Wallace, C. (2003). Emotional and social wellbeing: National policy context. *Australasian Psychiatry*, 11, S45-S50.

Slade, T., Johnston, A., Teesson, M., et al. (2009). *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra, Australia: Commonwealth of Australia Department of Health. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-m-mhaust2>

Social and Emotional Wellbeing and Mental Health Services in Aboriginal Australia (2017), <http://www.sewbmh.org.au/page/3662/culturally-specific-screening-tools>, accessed 2/09/2017.

Stiarifian, Farzad, (2004). *Cultural Conceptualisations in English Words: A Study of Aboriginal Children in Perth, Language and Education*. The University of Western Australia, School of Humanities.

Swan, P. & Raphael, B. (1995). *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report*. Canberra: Commonwealth of Australia.

Tylee, A., Haller, D.M., Graham, T., Churchill, R., Sanci, L.A. (2007). Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet*. 369, 1565–1573.

Van Dyke, N., Maddern, C.M., Walker, R. & Reibel, T. 2014. *Young People’s Experiences with Health Services – Final Report*. Commissioner for Children and Young People, Perth, WA

Vicary, D., Westerman, T., (2004). ‘That’s just the way he is’: Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3(3).

Western Australian Mental Health Commission. (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth, Western Australian Mental Health Commission.

Westerman, T. (2004). Engagement of Indigenous clients in mental health services: What role do cultural differences play? *Australian e-Journal for the Advancement of Mental Health*, 3(3).

Westerman T. (2010) Engaging Australian Aboriginal youth in mental health services. *Aust Psychol*. 45, 212–222.

Williamson, A.B., Raphael, B., Redman, S., Daniels, J., Eades, S.J. & Mayers, N. (2010). Emerging themes in Aboriginal child and adolescent mental health: Findings from a qualitative study in Sydney, New South Wales. *Medical Journal of Australia*, 192(10), 603-605.

World Health Organization. (2005). *Promoting Mental Health Concepts Emerging Evidence Practice, A Report of the WHO*. Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne.

Wright, M., O’Connell, M., Jones, T., (2013). Open Hearts, Open Hands: A Spiritual Journey of Change. Evaluating change in the provision of mental health and drug and alcohol services to Nyoongar families in the south-east metropolitan corridor of Perth, Western Australia [http://www.healthinfonet.ecu.edu.au/uploads/resources/28370\\_28370.pdf](http://www.healthinfonet.ecu.edu.au/uploads/resources/28370_28370.pdf)

Wright, M., O’Connell, M., Jones, T., Wally, R., and Roarty, L. (2015) *Looking Forward Aboriginal Mental Health Project: Final Report*. December 2015. Telethon Kids Institute, Subiaco, Western Australia

Zubrick, SR., Silburn, SR., Lawrence, DM., Mitrou, FG., Dalby, RB., Blair, EM., Griffin, J., Milroy, H., De Maio, JA., Cox, A., Li, J. *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research, 2005.



