Improving mental health of Koori men:
A study of help seeking and mental health service response

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This study is submitted to fulfil the requirements for the award of Doctor of Philosophy at Monash University

March 2011
Dedication

I dedicate this work to

My beloved wife, Natalie, who encouraged me to travel to Australia to pursue ‘my dream’ whilst being painfully aware that in doing so, she would be without me at the birth of our daughter.

My son, Daniel, who at the tender age of two, struggled to hide the pain of not having his father around for more than a year.

My daughter, Sydelle, who I first met when she was six months old and who always lifted her mother’s spirit with her hearty laughter when I was away.
Mirrm Laigurn (leading male kangaroo) continually fight to keep control over their females. The colours and designs in this drawing demonstrate the big fella’s dominance in the mob. Artist: Mick Harding (Reproduced with permission)

Like Mirrrm Laigurn, it is hoped that this work will pave the way for future research aimed at restoring the Koori man to his rightful place in society.
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## Abbreviations

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<td>Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>AMHS</td>
<td>Area Mental Health Service</td>
</tr>
<tr>
<td>CA</td>
<td>Cultural Advisor</td>
</tr>
<tr>
<td>CATT</td>
<td>Crisis Assessment and Treatment Team</td>
</tr>
<tr>
<td>CMHW</td>
<td>Community Mental Health Worker</td>
</tr>
<tr>
<td>GEGAC</td>
<td>Gippsland and East Gippsland Aboriginal Corporation</td>
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<tr>
<td>KHLO</td>
<td>Koori Hospital Liaison Officer</td>
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<td>KMHLO</td>
<td>Koori Mental Health Liaison Officer</td>
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<tr>
<td>LRH</td>
<td>Latrobe Regional Hospital</td>
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<tr>
<td>RDAC</td>
<td>Ramahyuck District Aboriginal Corporation</td>
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<td>SEW</td>
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List of presentations and awards


2. Isaacs, A. (2009). Engaging Indigenous men in rural areas for mental health services research. Award winning presentation at Public Health Association of Australia and Australian Epidemiological Association joint workshop showcasing higher degree public health student research in epidemiology and public health in Victoria held at La Trobe University City Campus on 5th November, 2009.

3. Isaacs, A. (2008). Award for Outstanding Contribution presented by Monash University at the 2008 Higher Degree by Research Student Poster Exhibition. (See Appendix 5)
Abstract

Mental illness is widespread among Indigenous people in Australia and mental disorders are reported to be the leading cause of disease burden after cardiovascular disease. Indigenous males are affected by mental health problems at higher rates than their non-Indigenous counterparts. This is evident from the higher levels of psychological distress, higher hospitalisation rates and higher death rates due to mental and behavioural conditions among Indigenous men. However Indigenous men do not commonly receive treatment from mental health services.

The literature highlights two important reasons. One is that they do not access mainstream mental health services in proportion to their need and the second is the suggestion that mental health services may be culturally inappropriate and inaccessible. This study sought to establish the qualitative factors that influence Indigenous male help seeking and aspects of the service setting that impede access. The specific objectives of this study were fourfold. The study sought to first examine the factors that influence Indigenous male help seeking for mental health problems. Second, the study aimed to identify the factors affecting utilisation of mental health services. Third, the study intended to determine the barriers and facilitators to care for Indigenous men with mental disorders and finally, it sought to identify strategies to improve access to and utilisation of mental health services by Indigenous men in Gippsland.

The study was informed by the guidelines on values and ethics proposed by the National Health and Medical Research Council, the Decolonising Methodology of Linda Tuhiwai Smith as well as methods suggested by other authors who have worked in the field of Indigenous health. Within a Qualitative Description design,
semi-structured interviews were utilised to obtain narratives from Koori men and
carers and mental health professionals. A total of seventeen Koori were interviewed
including men, carers, social and emotional wellbeing workers and a hospital liaison
officer. In addition, 28 staff from the mental health services were interviewed
individually or in focus groups.

A total of thirteen themes emanated from the data. These have been categorised
into three results chapters. The first results chapter relates to obstacles faced by
Koori men in seeking help for a mental illness. This chapter covers the four themes
of recognising a mental illness, disclosing one’s mental illness, reluctance to contact
a service, and alternate ways of coping. The second results chapter focuses on the
mismatch between mainstream mental health services and includes the three
themes, barriers to gaining entry into services, barriers to engagement with services
and staffing problems in the services. The final results chapter relates to future
directions and outlines six themes. The first two themes relate to improving help
seeking among Indigenous men. They include improving mental health awareness
among the Community and empowering men to talk about problems. The next four
themes relate to rendering services more accessible. They include, building men’s
confidence in services, developing relationships with the Koori community,
enhancing flexibility of services and strengthening the role of the Koori Mental
Health Liaison Officer.

The results are then discussed in relation to the literature on help seeking and
available services. In this section, the unique experiences of Koori men with regard
to help seeking and service utilisation together with implications for future research
and interventions are discussed.
Other co-incidental learnings from the study include the need to provide for a long
time frame for research involving Koori men, the need to adopt a flexible approach
to research and the need to engage cultural advisors who represent different
sections of the Koori community.

The distinctive aspects of this research are multiple. First, it provides the first in-
depth exploration of help seeking among Indigenous men with mental health
problems. Second, it sheds light on the various barriers to Indigenous men
accessing mental health services. Third, it gives voice to Koori people to indicate
how they expect mental health services to be culturally appropriate. Fourth, it
provides the first report of dual perspectives of Koori men and carers as well as
service providers in improving services. The best solutions for a difficult situation are
usually those that include perspectives of all stakeholders. Finally, the research was
carried out in a culturally appropriate way and in so doing the researcher has not
only been able to identify real challenges and solutions but has also taken a step
forward in improving the reputation of research among Indigenous men in
Gippsland. Future research will have to determine the feasibility and usefulness of
the interventions suggested.

Key words: Indigenous men, mental health problems, help seeking, mental health
services, service utilisation, cultural appropriateness, cross cultural services,
Indigenous research methodology, cultural consultants.
Declaration

I certify that this thesis titled, 'Improving mental health of Koori men: A study of help seeking and mental health service response' contains no material which has been accepted for the award of any other degree or diploma in any university or other institution and I affirm that to the best of my knowledge the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signed: Anton Neville Isaacs

Date: March 2011
Notice 1
Under the Copyright Act 1968, this thesis must be used only under the normal conditions of scholarly fair dealing. In particular no results or conclusions should be extracted from it, nor should it be copied or closely paraphrased in whole or in part without the written consent of the author. Proper written acknowledgement should be made for any assistance obtained from this thesis.

Notice 2
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Acknowledgements

My dream of pursuing my PhD has been an emotional and insightful journey. Several people have travelled this journey with me helping me along the way.

I owe my deepest gratitude to my supervisor, Associate Professor Darryl Maybery who was instrumental in helping me prepare this thesis. I am also indebted to Associate Professor Marlene Drysdale for giving me innumerable opportunities and for ensuring that I kept my sanity through it all. I would like to thank Professor Mark Oakley Browne for offering to take over my supervision at the start of my candidature as well as Peter Waples-Crowe and Associate Professors Priscilla Pyett and Janice Chesters for supervising the various stages of my research. My thanks also go to Nicole Cassar, for sharing her experience in Indigenous mental health with me.

I would also like to show my gratitude to Hilton Gruis for taking me under his wing and for vouching for me in the Koori community. I would especially like to thank Dr. Ali Khan for supporting my work and Hugh Pepper for agreeing to be my cultural advisor, for supporting my work and for being my first and best Koori friend. Thanks also go to Larry Levi and Phil Perry for being my cultural advisors and Community members, Wayne Thorpe, Mick Harding and Aunty Carol Taylor for their support. I am indeed indebted to all the participants of this research, without whose support, this would not have been possible.

I would like to thank Suzanne Lampitt, Berwyn Lampitt, Gill Kerr, Kim Joyce and Helen Rawlings for facilitating recruitment of mental health staff. My thanks also goes to Helen Chambers for her warmth and support, Dr. Andrea Reupert for her
suggestions on parts of the manuscript as well as Julie Irvine and Dr. Eleanor Mitchell for assistance with formatting.

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Chapter 1

Background and setting

Background of the research

Mental illness is widespread among Indigenous people in Australia (Hunter, 2003; Swan & Raphael, 1995). Mental disorders are reported to be the leading cause of disease burden among Indigenous people after cardiovascular disease and are responsible for 16 percent of the total DALYs (Disability Adjusted Life Years) (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). Risk factors for high prevalence conditions such as depression are also high among Indigenous people. Data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) for 2004-05 indicate that Aboriginal people aged 18 and above experienced ‘High’ or ‘Very High’ non-specific psychological distress at twice the rate of their fellow citizens (Australian Bureau of Statistics, 2006b).

Furthermore, Indigenous males appear to be affected by mental health problems at higher rates than non-Indigenous males. Twenty one percent of Indigenous males experienced a high or very high level of psychological distress which is more than twice the rate for non-Indigenous males (Australian Bureau of Statistics, 2006b). Hospitalisation rates for mental and behavioural disorders were also higher at 2.1 times that for non-Indigenous males in most parts of the country (Australian Institute of Health and Welfare, 2008). Additionally, the number of deaths due to mental and behavioural conditions is also higher for Indigenous males than for non-Indigenous males. In the period 2001 – 2005 deaths due to mental and behavioural disorders of

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*The term Indigenous is used interchangeably with Aboriginal to refer to both Aboriginal and Torres Strait Islander peoples of Australia.*
Indigenous men living in the states of Queensland, Northern Territory, Western Australia and South Australia were 5.8 times that of non-Indigenous males (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008).

There are multiple reasons suggested for these higher rates of mental health problems among Indigenous people. They include past government practices of removal from family (Stolen Generations) as well as substance abuse and poverty (Emden, Kowanko, de Crespigny and Murray, 2005; O’Brien, 2005; Vicary and Bishop, 2005). Indigenous peoples’ ill health is invariably dove-tailed with accounts of loss of land, family and culture, and of exclusion from ‘full participation in the social, political and economic life of post-invasion Australia’ (Saggers and Gray, 2007, p.17).

This has resulted in widespread poverty among Indigenous people (Morrissey, 2003). A significant proportion of Indigenous Australians live in conditions that can be classified as Absolute poverty which refers to ‘the lack of or limited access to the fundamental requirements of health, such as food, clean water and shelter’ (Walter and Saggers, 2007, pp. 92-93). This type of poverty does not entail just having unsatisfied material needs or being undernourished. It is often accompanied by a degrading state of powerlessness where poor people have to accept daily humiliations without protest. Often, they cannot provide for their children and have a strong sense of ‘shame and failure’ (Department of Economic and Social Affairs, 2009) that often results in chronic stressful circumstances. While much has been written about these key factors underlying Indigenous health and mental health problems, the central focus of this thesis is on factors that might be more amenable to change.
Another possible reason for the poor mental health status of Indigenous people is that they do not access mainstream mental health services in proportion to their need (Westerman, 2004). The consequences of not seeking timely professional help for mental health problems include worsening of symptoms and slower recovery (Lincoln & McGorry, 1995) as well as negative social and educational outcomes (Kessler, Foster, Saunders, & Stang, 1995). Moreover, when suicidal ideation complicates symptoms, the situation is all the more dire. In one Adelaide survey, only 14 percent of the Aboriginal people who had a diagnosable mental illness at the time of their suicide had sought treatment for their illness (Aboriginal Health Organization & The Mental Health Research and Evaluation Centre, 1991).

Utilisation rates presented in national reports can sometimes give the wrong impression. For instance, according to one national survey, Indigenous Australians contact community mental health care services at rates that are almost 2.5 times that for other Australians (Australian Institute of Health and Welfare, 2009b). However, this figure may be misleading as it only portrays the number of clients who contact the services. It does not reveal the proportion of those Indigenous people who are in need of mental health services but do not contact them. This proportion referred to as the unmet need for mental health services is suspected to also be much higher for Indigenous people than it is for non-Indigenous people. In other words, although some Indigenous people access mental health services at rates that are higher than that of non-Indigenous people, there is still a large number of them who need services but do not access them. Underutilisation has largely been attributed to cultural inappropriateness of these services (Kowanko, Crespigny, Murray, Groenkjaer, & Emden, 2004; Wenitong, 2002; Westerman, 2004).

Additionally, it is also reported that Indigenous men in distress are less likely to seek help from mental health services than Indigenous women (Australian Institute of
Health and Welfare, 2009a; Wenitong, 2002). Gender differences have been reported to be a reason for this difference (Wenitong, 2002). These gender differences are sometimes explained as ‘men’s and women’s business’ (Maher, 1999). As a consequence, Indigenous men are not comfortable accessing services run by women. It was therefore imperative for this research to also follow these gender protocols and as outlined in chapter 3, this study focussed only on Indigenous men.

This thesis seeks to establish the qualitative factors that influence Indigenous male help seeking and aspects of the service setting that impede access. It aims to offer some answers to questions such as, why are Indigenous men less likely to seek help from mental health services? What are the factors that prompt or hinder help seeking among Indigenous men? And how can mental health services be made more user-friendly for Indigenous men?

The literature review outlined in chapter 2 highlights that there is little evidence concerning factors that influence the help seeking behaviour of Indigenous men and their utilisation of mental health services. There is also a paucity of literature on what constitutes cultural appropriateness in a mental health service. Furthermore, the 1996 National Standards for Mental Health Services highlights that under-utilisation of services by Indigenous people should be further investigated (Australian Health Minister’s Advisory Council’s National Mental Health Working Group, 1996).

Before outlining the literature, the following briefly draws attention to topics that may impact upon Indigenous mental health as well as those that relate to this research. The topics outlined below include, the effect of colonisation on Indigenous mental health, Indigenous concepts of mental health, a brief overview of mental disorders prevalent among Indigenous people, the history of Aboriginal Gippsland and the
research setting, the background of the researcher and the researcher’s introduction to Aboriginal and Torres Strait Islander peoples.

**Affects of colonisation on the mental health of Indigenous people**

The deleterious effects of colonisation have been widely considered as the major cause of the high prevalence of mental health problems among Indigenous people (Swan & Raphael, 1995). Colonisation and its ongoing consequences have been thought to disrupt the balance of inter-relating spiritual, environmental, social, political and other factors (Swan & Raphael, 1995). In addition, forced separation of children of mixed parentage from their families (Stolen Generation) and institutionalisation in the past have resulted in an increased predisposition to mental illnesses such as depression, anxiety and emotional distress (Human Rights and Equal Opportunities Commission, 1997). Assimilation policies that were presumably meant to give Aboriginal people an identity, albeit a different one from their own ultimately resulted in them having none at all due to the systemic racist attitudes towards all things Aboriginal. The phrase, ‘too white to be black and too black to be white’ is commonly echoed in Aboriginal communities. Paradies (2007) reviewed 138 empirical studies on racism and health and found that there was overwhelming evidence of a relationship between experiences of racism and poor mental health outcomes.

Furthermore, reports from Victoria such as those by Richard Broome describe the dispossession of land of the Aboriginal people over a remarkably short time, in the nineteenth century, and their relocation to mission stations or to new lands which were barren and unsuitable for living on (Broome, 2005). These relocations also
disrupted family, clan and tribal groupings which have a bearing on the mental health of these Communities\(^2\) today.

**Indigenous concepts of mental health and illness**

Aboriginal concepts of mental health and Illness are also known to differ from that of the mainstream. The ‘Ways Forward’ report by Swan and Raphael (1995) described Indigenous mental health as being holistic, involving spiritual, social, cultural, physical and mental well-being and issues related to land and way of life. They describe mental health as an interaction of the individual, the community as well as the environment:

\[
in \text{ways which promote subjective wellbeing, the optimal development and use of mental abilities, the achievements of individual and collective goals consistent with the attainment and presentation of conditions of fundamental equality (Swan \\& Raphael, 1995, p.20)}
\]

Mental health from the Aboriginal and Torres Strait Islander perspective has also been defined as:

\[
a \text{positive state of wellbeing in which the individual can cope with the normal stress of life and reach his or her potential in work and community life in the context of family, community, culture and broader society (Social Health Reference Group, 2004, p.3).}
\]

Ypinazar, Margolis, Haswell-Elkins, and Tsey (2007) have also attempted to describe the Indigenous concept of mental health. They argue that there are five themes within this concept:

- Culture and spirituality
- Family and community kinships

\(^{2}\) The term ‘Community’ has been used in this work to refer to country (land), family ties, belonging and shared experiences of Aboriginal people.
Historical, social and economic events

Fear and education and

Loss in its many manifestations.

The term Social and Emotional Wellbeing (SEW) is commonly used instead of mental health by Aboriginal and Torres Strait Islander people since it relates more to a holistic concept of health (Australian Health Ministers, 2003).

Social and Emotional Wellbeing has also been described in the traditional culture of the Karajarri people of Western Kimberley. According to them, the seat of wellbeing in the body is referred to as Ngarlu - ‘the place of the inner spirit’ (Roe, 2001). Ngarlu always has to be kept clear. For example, if an individual has ill feelings towards another, it has to be cleared through open communication with the concerned person. Ignoring one’s Ngarlu and suppressing one’s emotions could lead to mental health and wellbeing problems. It is thought that older traditional people know this inner spirit very well although younger individuals have to be taught about its importance. There are other traditional explanations for mental health problems and mental illness. For example, in some parts of Australia, mental illness can be perceived as ‘payback’ for past transgressions or even being ‘married the wrong way’ (Vicary & Bishop, 2005).

The National Mental Health Plan 2003 - 2008 refers to mental illness and mental health problems as separate entities. Mental illness refers to ‘a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities’ while mental health problems are ‘common mental health complaints’ that are experienced as a short-term reaction to life stressors (Australian Health Ministers, 2003, p.5). These definitions are also espoused by the National Aboriginal and Torres Strait Islander Council (Social Health Reference Group, 2004).
Overview of mental disorders commonly reported among Aboriginal people

In Victoria, the most common mental health diagnoses for registered Aboriginal male clients are schizophrenia and other related disorders (26%), anxiety disorders (17%), mood disorders (11%) substance use (other than alcohol use) (7%) and alcohol use disorder (6%) (Victorian Government Department of Human Services, 2007). A brief description of these disorders is given below.

Schizophrenia

Schizophrenia is a major mental illness and ‘is characterised by disturbances in thought and verbal behaviour, perception, affect, motor behaviour and relationship to the external world’ (Ahuja, 2002, p.56). Common features of schizophrenia include:

- Thought and speech disorders such as blocks in the thought process, autistic thinking (where thinking is directed by private and illogical rules), delusions (false unshakable beliefs which are incongruent with the person’s socio-cultural and educational background) and neologisms (where the person forms absurd new words or phrases)
- Disorders of perception or hallucinations wherein the person has perceptions in the absence of stimuli. The most common hallucinations among persons with schizophrenia are auditory ‘third person hallucinations’ where they hear voices of others speaking about them in the third person.
- Disorders of affect where persons are unable to establish emotional contact with others and demonstrate inappropriate emotional responses to thoughts (e.g. laughing in a very serious situation).

Registered clients are those attending adult mental health services and consequently are more likely to have more severe disorders.
Disorders of motor behaviour include mannerisms, grimacing, repetitive strange behaviour as well as poor self care and grooming.

Negative symptoms include flat mood, inability to experience pleasure and social withdrawal (Ahuja, 2002).

Schizophrenia is a chronic illness and often affects patients lifelong (Priebe, 2007). The first episode usually takes place in adolescence and early adulthood and early interventions are thought to significantly improve chances of a full and speedy recovery (Early Psychosis Prevention and Intervention Centre, 2011)

**Anxiety disorders**

Anxiety is the commonest mental disorder encountered in the general population. Anxiety is a normal phenomenon characterised by a state of apprehension or unease which arises from anticipation of danger. However, it becomes an illness when anxiety causes significant distress and prevents normal functioning of the individual (Ahuja, 2002). Common features of anxiety disorders include tremors, restlessness, muscle twitches, palpitations (feeling one’s own heartbeat), dry mouth, dizziness, poor concentration, distractibility, irritability, inability to relax and difficulty to fall asleep.

Mild anxiety can be treated with self help strategies such as relaxation techniques and exercise (Jorm & Griffiths, 2006). However, more severe symptoms have to be treated either with medication or with behaviour therapies such as cognitive behaviour therapy (CBT) (Ahuja, 2002).

**Mood disorders**

Mood has been defined as ‘a sustained and pervasive emotional response which covers the whole psychic life’ (Ahuja, 2002, p.70). The most common mood disorder is depression and is characterised by a pervasive sadness and a loss of interest in daily activities, particularly those that were previously pleasurable. Thoughts of
death and a preoccupation of death is not uncommon in more severe depression. Depression is commonly associated with feelings of hopelessness, helplessness and worthlessness. Persons less than 40 years of age, usually complain of slowed thinking and activity. Interestingly anxiety commonly accompanies depression. Other physical symptoms such as easy fatigability and vague body aches are also observed (Ahuja, 2002).

Depression can be treated with medications or with psychological interventions or both depending on its nature and severity (Jorm, Allen, Morgan, & Purcell, 2009). Further details of depression can be found on the Beyond Blue website (See Beyondblue, 2009).

**Substance use disorders**

Substance use disorders are of two main types. They are classified as harmful use and dependence. According to the Australian version of the International Classification of Diseases (ICD-10-AM), when a person uses a substance such as alcohol in quantities that causes damage to their health, it is referred to as harmful use. Dependence typically refers to a strong desire to use the substance and develops after repeated use. Persons who have dependence have difficulty in controlling its use, persist in its use despite harmful consequences, and afford a higher priority to the drug than to other activities and obligations (National Centre for Classification in Health, 2004). Persons who use substances can also experience an episode of psychosis which includes ‘hallucinations, perceptual distortions, delusions, feelings of intense fear to ecstasy’ (Victorian Government Department of Human Services, 2007).

When substance use disorders occur concurrently with a mental disorder, it is referred to as co-morbidity or dual diagnosis. In dual diagnosis, both mental disorder
and the substance use disorder tend to worsen and their interaction compounds the person’s disability making it very difficult to treat (Sheehan, 1993).

**A brief history of Aboriginal Gippsland**

Gippsland which is located in the south east part of Victoria is named after George Gipps who was the governor of New South Wales at the time of European exploration (See Figure.1). Originally occupied by more than 4000 Aboriginal people known as the Kurnai ⁴, the area was more densely populated than others due to its pleasant climate (Morgan, 2004). Gippsland was occupied mostly by ‘Highland Scots’ led by Angus Macmillan who arrived in 1840 (Morgan, 2004). What ensued was a series of clashes and massacres resulting in the Kurnai being driven east and north into the hills and away from the central plain and lakes, which were coveted by

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⁴ Sometimes referred to as Gunai/Kurnai
the settlers (Morgan, 2004). As a result of the multiple massacres and disease epidemics, the Kurnai population of Gippsland declined dramatically (Pepper & D'Araugo, 1985). Broome (2005, p.119) states that new Aboriginal communities emerged after the 1850s when,

*remnant clans devastated by population decline and loss of land through colonial dispossession, looked to formerly hostile groups for wives, partners and perhaps unconsciously, the critical mass required to form new Aboriginal communities.*

After the dispossession of Aboriginal people of their land, a second onslaught emerged from the European settlers. Fuelled by a belief that they had to change the ‘blacks’ into ‘men and women in their own image’, missionaries set about ‘civilising’ and Christianising Aboriginal people restricting them to mission stations (Attwood, 1989, p.52). The major Aboriginal mission stations in Gippsland were at Ramahyuck and Lake Tyers (See Figure 2).

![Figure 2: Aboriginal mission stations in Gippsland and Victoria](image-url)
Ramahyuck mission was founded in the early 1860s by the Moravian missionary, Friedrich Hagenauer. It was ‘built on the north bank of the Avon river a few miles up river from lake Wellington’ (Pepper & D'Araugo, 1985, p.132). By the 1870s, Ramahyuck was considered the most successful mission station in the colony (Attwood, 1989). However, as the missionaries at Ramahyuck tried to convert Aboriginal ideas of place, time and the ‘individual-community nexus’ into western ways of thinking, things began to change for the worse (Broome, 2005).

Furthermore, removing children from their parents in the name of protection became customary on the reserves resulting in mounting Aboriginal frustration that led to many people leaving the reserves to look for work outside (Broome, 2005). Before long, the reserves became unhealthy places owing to communicable diseases spread by poor living conditions and ignorance of proper hygiene (Broome, 2005). By 1884, deaths due to illness rapidly increased in Ramahyuck and plans were afoot to close down the mission (Pepper & D'Araugo, 1985). In 1886, the Aborigines Protection Act was passed by the Victorian Government which deemed that only ‘Aboriginals’, half castes’ over the age of 34, ‘half caste’ women married to ‘Aboriginals’, children of ‘ Aboriginals’ unable to earn their own living and licensed ‘half castes’ were able to reside on reserves, while others had to leave (Broome, 2005, p.186). By 1908 Ramahyuck Mission was closed and its residents were sent either to Lake Tyers or to the wider community (Pepper & D'Araugo, 1985).

In 1957 the Aborigines Welfare Board (AWB) was formed which replaced the Board for the Protection of Aborigines. Observing the dilapidated state of housing and other living conditions at Lake Tyers mission, the AWB initially planned to carry out major renovations of the facilities on the mission but later trimmed it down to ‘urgent repairs’ due to the massive cost (Fletcher, Chesters, & Drysdale, 2007). The AWB later unsuccessfully tried to relocate the Lake Tyers residents to Morwell - a bustling
town in the Latrobe Valley \(^5\) (See Fig.3). The ownership of Lake Tyers mission was transferred to the Aboriginal community in 1971 (Pepper & D'Araugo, 1985). However, due to its geographical isolation, many residents from Lake Tyers moved to Sale and Morwell.

Over the years, as the Indigenous community in Sale grew, a permanent service became necessary for the Community. Ramahyuck District Aboriginal Corporation (RDAC) was established in 1992 in Sale (See Figure. 3) by the Elders of the local Community (Ramahyuck District Aboriginal Corporation & Central Gippsland Aboriginal Health Service [Nindedana Quarenook], 2008). There are three other Aboriginal Community Controlled Health Organisations in Gippsland. They are Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) based at Bairnsdale, Lake Tyers Aboriginal Trust based at Lake Tyers and Moogji Aboriginal Council at Orbost (See Figure. 3). Ramahyuck District Aboriginal Corporation (RDAC) based at Sale is the largest of them and has branches in Morwell and Drouin (recently opened).

Currently, there are no more traditional Kurnai people in Gippsland and with their passing, much of the Kurnai culture has been lost (Pepper & D'Araugo, 1985).

**The setting for the research**

Figure 3 below shows the various mental health services that are available in Gippsland. It also shows the location of the ACCHOS (red dots). Mainstream mental health services for Gippsland are provided by Latrobe Regional Hospital (LRH) located in Traralgon. LRH runs community mental health services at Traralgon, Sale

\(^5\) The Latrobe valley is an inland geographical region of Gippsland. It is nestled between the Strzelecki Ranges to the south and the Great Dividing Range to the north. The main towns of the Latrobe valley are Moe, Morwell and Traralgon.
and Bairnsdale (blue dots) as well as runs a 33-bed acute care unit at Traralgon (blue cross).

Figure 3: Mental health services and Aboriginal organisations in Gippsland

Since its inception, RDAC has grown into one of the most successful ACCHOs in Gippsland. It offers a variety of primary health care and health promotion services including Social and Emotional Wellbeing (SEW) services. The SEWB services for most of Gippsland are run by RDAC through the Woolartbe Werna project with workers based at Morwell, Sale, Bairnsdale and more recently at Drouin (Atkinson & Kerr, 2003). The Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) located in Bairnsdale to the East of Sale also provides a range of services and collaborates with RDAC in delivery of SEW services. At the time of commencing this research, GEGAC was in administrative transition and so were not in a position to be part of the project. Hence, the research was conducted under the auspices of RDAC in collaboration with LRH’s mental health services with a view to promote intersectoral collaboration. This study focussed on Aboriginal Communities of
Morwell, Sale and Bairnsdale since these were the largest Communities in Gippsland (See Table 1.).

Table 1: Distribution of Indigenous people in the study area by gender

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morwell</td>
<td>176</td>
<td>212</td>
<td>388</td>
</tr>
<tr>
<td>Sale</td>
<td>79</td>
<td>77</td>
<td>156</td>
</tr>
<tr>
<td>Bairnsdale</td>
<td>379</td>
<td>386</td>
<td>765</td>
</tr>
<tr>
<td>Total</td>
<td>634</td>
<td>675</td>
<td>1309</td>
</tr>
</tbody>
</table>

Source: ABS 2006 census data: cat. No 2068.0

Indigenous people in Gippsland mostly work in Aboriginal organisations with a few working in Indigenous related roles in Universities and other government health and community service organisations. Whilst Aboriginal communities around Australia are diverse and have different needs, delivery of mental health services is also not uniform across all Australian states and territories (Ash et al., 2007). Although mental health care for the entire region is delivered by a single service, little is known about the mental health needs of Indigenous people in the region.

Background of the researcher

I am an overseas trained public health physician. After completing my medical degree, I worked in a rural hospital in South India for a period of two years as a resident medical officer. That experience gave me a better understanding of the social determinants of health such as unaffordability of food and medication, difficulty understanding medication dosages and inability of people to reach the hospital because they had to travel long distances and negotiate mountainous terrain.
My interest in Indigenous mental health grows from experience in community mental health in India and my own Anglo-Indian culture. My interest in mental health began when I was asked to develop and coordinate the community mental health program of St. John’s Medical College in Bangalore, India which was initially funded by a matching grant from The Rotary Foundation (Isaacs, Neerakkal, Srinivasan, & Jayaram, 2006). This service with currently over 700 registered patients covering more than twenty five villages in Bangalore rural district was successful due to a combination of factors. First, care was taken to choose an appropriate name for the program ensuring that it was non-stigmatising and culturally acceptable. The program is called ‘Maanasi’ which refers to a girl who is knowledgeable and wise. Maanasi is a name that is considered auspicious and evokes positive feelings among people in the area. Second, the program was promoted by four female Community Mental Health Workers (CMHWs) who were identified from the local area and were able to take the service to the people thereby making it acceptable. Finally, the service was integrated with other general medical services which further served to reduce any stigma associated with contacting mental health services.

Another factor that contributed to my interest in Indigenous mental health was my belief that my own culture could help me understand the Gippsland Indigenous community better. I belong to the Anglo-Indian community, which is a direct outcome of European colonisation in India. I therefore have some experience and a subjective understanding of the consequences of colonisation such as issues around race and identity. In my home state of Kerala, there is an uneasy co-existence between the Anglo-Indian community (my heritage) and the mainstream society. Anglo-Indians are the minority and have a westernised culture, speaking predominantly English. Although for the most part, there is harmony between the two communities, at times, there are rumblings of dissatisfaction with each other. As a result, I have often felt confused about my identity. On the one hand, elements of
the mainstream Indian culture are inextricably ingrained in me, while on the other hand, I felt it necessary to cling to ‘my culture’ which has become increasingly hard to define. I therefore felt that my background would help me better understand some of the conflicts and tensions experienced by Indigenous people with regard to identity and culture.

**Researcher’s introduction to Aboriginal and Torres Strait Islander people**

Being an international student with no previous exposure to Aboriginal and Torres Strait Islander people, it was necessary for me to get a feel of the Community, its people and what they stood for. I had to familiarise myself with their history, their culture and way of life. The following describes my initial endeavours at getting to know Australia’s Indigenous people.

At the outset, I visited the Koori Heritage Trust at Melbourne to get a glimpse into some of the history, images and artwork of Koori 6 people. I also attended training programs on cultural competence both locally as well as externally by Tracy Westerman’s Indigenous Psychological Services (Indigenous Psychological Services, 2004 - 2009). The Indigenous Health Unit at Monash University’s Department of Rural and Indigenous Health at Moe was very supportive of me and my work and offered me a part time position as lecturer. Being a public health physician by training, I lectured on the health indicators of Indigenous people to medical and health sciences students. Teaching Indigenous health together with informal discussions with knowledgeable members in the field, I educated myself about the history of Aboriginal and Torres Strait Islander peoples.

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6 Koori (also spelt Koorie) refers to the Aboriginal people of Victoria and South-eastern Australia
I was also invited to accompany a group of medical and nursing students on an Aboriginal cultural tour to Iga Warta in South Australia to learn about the Adnyamathanha people. At Iga Warta, I wondered at the mountain that looked like a resting eagle, contemplated the unopened damper that was left behind by the mother who went in search of her children and listened to the stories narrated by the Elders as we sat around the evening fire. These experiences helped me begin to understand the concept of The Dreaming. Fielke and colleagues have referred to this type of training as ‘cultural immersion training’ where one learns about the culture of Indigenous people by living with their communities (Fielke, Cord-Udy, Buckskin, & Lattanzio, 2009). While these introductions did not provide me with specific knowledge of the Victorian Community that was to be researched, it still gave me a broad introduction and valuable insight into Australian Aboriginal people and their history. Apart from these endeavours, I also made multiple visits to the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) at Melbourne to discuss the possibility of conducting Indigenous mental health research with key individuals there. Further details of the process of deciding the focus of research is discussed as part of the ethical aspects of the research under Methodology in Chapter 3.

To sum up, this research was influenced by several factors. The poor state of Indigenous mental health and the need to do something tangible about it was the primary driver of this study. Moreover, a lack of evidence about the help seeking behaviour of Indigenous people as well as the ongoing need to indentify strategies that could enable them to utilise mental health services more easily seemed to be a possible focus for research.
My cultural heritage which is an outcome of European colonisation in India and my early interactions with Indigenous people and their organisations helped me understand the issues involved in Indigenous mental health. This and my previous experience with rural mental health services provided a firm platform on which to develop my research questions but more importantly to establish and build my relationship with the Kurnai people of Gippsland as an essential part of my research relationship.
Chapter 2

Review of the Literature

The focus of this review is to glean the literature for evidence on Indigenous men's help seeking for a mental illness and to examine the literature regarding the interactions between mainstream mental health services and Indigenous men. Since literature on Indigenous men was not forthcoming, literature relating to Aboriginal people as a whole and non-Indigenous people is included. The chapter commences with a discussion of the various factors that affect the different steps of help-seeking for a mental health problem. These steps are modified from an original model proposed by Saunders (1993) and literature about factors affecting help seeking in the general population is also contrasted with those influencing the Indigenous population.

Following this is a discussion of current mental health services that are available for Indigenous people. Some of the shortcomings of ACCHO based mental health services are also highlighted with the consequent need for future research aimed at addressing these drawbacks. A review is then conducted of all the exemplars of collaboration between Aboriginal organisations and the mainstream mental health services aimed at designing new services for Indigenous people and improving existing ones. Finally, the key policies that address mental health services for Indigenous people are discussed. The review ends with a summary of the findings and the key gaps in knowledge that informed this research.

Help seeking for a mental illness

Many people do not access mental health services even when they meet criteria for a mental disorder (Cepeda-Benito & Short, 1988; Crabb & Hunsley, 2006). Reasons
for this phenomenon are multiple and can be explained by the process of help-seeking which has been defined as ‘the active search for resources that are relevant for the resolution of [a] problem’ (Zartaloudi & Madianos, 2010, p.662). Although there are studies that list the various factors that affect help-seeking (Gulliver, Griffiths, & Christensen, 2010), few reports theoretically group these factors into the process of seeking help for a mental illness. The latest study that attempted this, conceptualised the process as four consecutive steps (Saunders, 1993). They are:

1. Recognising the problem
2. Deciding that therapy (treatment) might help
3. Deciding to seek treatment and
4. Contacting the mental health service

These steps were arrived at by interviewing individuals who had contacted the mental health service for their mental health problems. However, only a fraction of those with a mental illness actually reach professional services. Of the 3.2 million people in Australia aged 16-85 years who had a mental disorder in the past twelve months, just over a third (34.9 percent) accessed mental health services for their mental health problem (Burgess, et al., 2009). The shortcoming of Saunders’ model therefore is that it does not take into consideration those who have not reached a professional service. This is extremely important in regard to the present study.

Many people with a diagnosed mental disorder do not believe that help is necessary. In a recent national survey, 86 percent of those with a mental disorder who were not receiving treatment said that they did not need any type of help (Meadows & Burgess, 2009). Additionally, many people choose informal strategies to manage their mental health problems. Studies from the 2007 National Survey of Mental Health and Wellbeing found that of the young adults aged 16-25 years who had a 12 month diagnosis for mental disorder, 49 percent used support services
(such as counselling) or self management strategies whereas less than half that percentage (23.3%) used formal psychiatric services for their mental health problems (Olesen, Butterworth, & Leach, 2010). In this context, and considering emerging literature, the Saunders model was modified to include new steps as follows:

1. Recognising the problem
2. Deciding that help is necessary
3. Deciding to seek help
4. Deciding the type of help needed and
5. Contacting the mental health service

At the onset of symptoms, people may or may not recognise that they have a mental health problem. Once they do recognise the problem, they may or may not decide that they need help. Once the decision is taken that help is necessary, individuals then have to decide to seek help. The next step is to decide the type of help they need. Finally, they have to contact the service that they have chosen. However, progressing from one step to the next in the process of help seeking can take time. Among those who do contact mental health services, there is usually a delay between the onset of symptoms of a mental illness and seeking professional help.

Studies from the United States suggest that the time between onset of symptoms and first contact with a health professional can range between 6 and 14 years depending on the type of disorder (Christiana, et al., 2000; Kessler, Olfson, & Berglund, 1998). However, an Australian study indicates that the median length of delay between symptom onset and contact with services was four years with a mean of just over nine years (SD = 11.1) (Thompson, Hunt, & Issakidis, 2004).
Whatever the length of the delay, it seems that individuals generally do not contact services immediately after the appearance of their psychological symptoms. Each individual starting the process of help seeking for a mental health problem can face challenges at one or more of these steps. While some people might find certain steps challenging, others might find other steps difficult to overcome. Difficulty in overcoming any of the above steps can cause a delay in contacting services for a mental health problem. The following summarises literature relevant to the five steps outlined above. Factors affecting each step are described with the help of a table. Initially outlined is literature pertaining to the mainstream population according to barriers and facilitators of the particular step. Each help seeking step concludes with a focus on the level of knowledge in the literature in regard to Indigenous men.

**Step: 1. Recognising the problem**

The most frequently endorsed reason for a delay in contacting services for a mental illness is a lack of knowledge of the symptoms of mental illness and available services (Thompson, et al., 2004; Thompson, Issakidis, & Hunt, 2008). This lack of knowledge prevents people from recognising that they have a problem which is the first step in the process of help seeking for a mental illness (Jorm, et al., 1997; Saunders, 1993). Recognising the problem is neither easy nor straightforward. Some individuals can be unaware that they have a problem until a crisis occurs (Commonwealth of Australia, 2004). The knowledge of mental disorders and what to do about them has been referred to as 'Mental Health Literacy' by (Jorm, et al., 1997). Although there have been improvements in mental health literacy levels in the Australian general population in the last decade, the levels continue to be low (Jorm, Wright, & Morgan, 2007). The facilitators and barriers to recognising a problem for the mainstream and Aboriginal people are given in Table 2.
There are several factors that hinder an individual’s conscious recognition of symptoms of a mental health problem. For instance, symptoms of depression may be explained away as normal reactions (e.g. sadness) to marital, familial or situational problems (Yokopenic, Clark, & Aneshensel, 1983).

Table 2: Factors influencing recognition of a problem for the general population and Aboriginal people

<table>
<thead>
<tr>
<th>Group</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>Not considered an illness</td>
<td>Severe symptoms such as</td>
</tr>
<tr>
<td></td>
<td>Confused with physical illness</td>
<td>suicidal ideation and feelings of</td>
</tr>
<tr>
<td></td>
<td>Severe psychological disability</td>
<td>worthlessness in others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High distress levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher education status</td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>Different cultural explanations for</td>
<td>Not known</td>
</tr>
<tr>
<td></td>
<td>depression-like symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge about mainstream</td>
<td></td>
</tr>
<tr>
<td></td>
<td>concepts of mental illness</td>
<td></td>
</tr>
</tbody>
</table>

While short term reactions to stressors are normal, depression is usually diagnosed only when these symptoms are long standing (at least for two weeks). Perhaps, it is therefore not difficult for people to mistake depressive symptoms for a normal reaction to common life stressors. This has been supported by other studies where depression is not considered an ‘illness’ or its symptoms are not labelled as depression (Kermode, Bowen, Arole, Pathare, & Jorm, 2009; Patel, 1996). This finding even prompted one author to question if the word ‘mental’ should be dropped (Patel, 1996).

In some traditional African communities, mental health problems have been attributed to spiritual causes as well, such as ‘evil forces’ and witchcraft (Nsereko, et al., 2011). Punishment from God and personal weakness has also been believed by
some to be a cause for mental illness (Sadik, Bradley, Al-Hasoon, & Jenkins, 2010). In addition, Individuals with a severe psychiatric illness such as psychosis may be cognitively challenged and thereby not be in a position to recognise that they have a problem (Regier, et al., 1993).

Studies from developing countries have also indicated that there is a tendency for clients with depression to present with multiple physical complaints (Okello & Neema, 2010; Patel, Gwanzura, Simunyu, Lloyd, & Mann, 1995; Patel, Pereira, & Mann, 1998) opening up the possibility of a physical component to depression. However, findings from world mental health surveys have shown that although there is a strong association between depression-anxiety disorders and multiple somatic complaints including pain, the later is not part of depression symptomatology (Gureje, et al., 2008; Scott, et al., 2007).

Facilitators of problem recognition are few. In the case of depression for instance, it is more readily identified by others when obvious symptoms of suicidal ideation and feelings of worthlessness are reported (Burns & Rapee, 2006). In addition, those with higher education status and high distress levels have also been found to better recognise mental health problems (Yokopenic et al., 1983).

*Problem recognition among Indigenous people*

Two barriers, cultural differences and differing epistemologies have been identified as barriers to recognition of mental health problems among Indigenous people. Aboriginal people who adopt more traditional concepts of health are known to have different explanations for depressive symptoms. Vicary and Westerman (2004) point out that in some traditional Aboriginal communities depression-like symptoms are not perceived as treatable conditions but as a characteristic of the individual and are
referred to as, ‘that’s just the way he is’ (p.6). Individuals complaining of such symptoms are therefore not considered by their Community as needing treatment.

Furthermore, a lack of knowledge of mainstream concepts of mental disorders also impedes problem recognition among Indigenous people. Although knowledge and understanding of mental illness among less traditional Communities such as those in Gippsland are not yet known, it is likely that knowledge of mental health problems and mental disorders is low within the Indigenous population. In one study from the Northern Territory, Eley et al. (2007) report that Indigenous clients and their family members stated that they did not fully understand mental illness. While there are various explanations for the high prevalence of mental health problems and mental illness among Indigenous people, there is a paucity of literature on Indigenous understandings of what constitutes a mental illness. It is thought that one reason for this lack of knowledge is Aboriginal peoples’ discomfort in talking about mental illness and their inclination to change the topic when it is brought up (Dudgeon, Garvey, & Pickett, 2000). Currently there is no evidence on facilitators of problem recognition by Indigenous people.

Recognition of a problem is therefore the first and perhaps most important prerequisite for service utilisation and while there is evidence of mental health literacy levels in the general population, similar evidence for Aboriginal people and men in particular is not available. An understanding of mental health literacy among Indigenous people is necessary to design culturally appropriate mental health awareness programmes for Indigenous men.

**Step: 2. Deciding that help is necessary**

Once a problem is recognised, the next step is to decide that help is necessary. This is significant in that 86 percent of those with a mental disorder who were not
receiving treatment did not believe that they needed any type of help (Meadows & Burgess, 2009). In another study from Canada, 24 percent of individuals reporting a suicide attempt, did not perceive a need for help in the previous year (Pagura, Fotti, Katz, & Sareen, 2009). Factors influencing the decision that help is necessary are listed in Table 3.

**Table 3: Factors influencing the decision that help is necessary for a mental health problem in the general population and Aboriginal people**

<table>
<thead>
<tr>
<th>Group</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>Self-reliant attitude (the need to be tough &amp; proud)</td>
<td>Severe psychological distress, Higher education status, Support from family and friends, GPs and intimate partners</td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>Not known</td>
<td>Not known</td>
</tr>
</tbody>
</table>

A key barrier as to why people decide that help is not necessary relates to a ‘self-reliant’ attitude. Many people with depressive symptoms label themselves as ‘psychologically trouble-free’ (Yokopenic, et al., 1983). This self-reliant attitude has also been described in rural and remote areas where men are expected to be tough and proud and so do not believe they need help for mental health problems (Fuller, Edwards, Procter, & Moss, 2000).

There are multiple factors that facilitate the decision that help is needed for mental health problems. The most important factor that prompts this decision is the severity of psychological distress (Deane & Chamberlain, 1994; Thompson, et al., 2004; Yokopenic, et al., 1983). Education and the presence of social support from family and friends also plays an important role in this decision making process (Angermeyer, Matschinger, & Reidel-Heller, 1999; Rickwood & Braithwaite, 1994; Thompson, et al., 2004). In one Australian study of 73 males, 96 percent stated that
their decision to seek treatment was influenced by others and of these 37 percent stated that if not for others they would not have sought treatment at all (Cusack, Deane, Wilson, & Ciarrochi, 2004). The study also reported that GPs and intimate partners were the strongest influences for those men.

*Deciding that help is necessary among Indigenous people*

No literature was found about Indigenous people generally or males specifically making a decision to seek help. This is a key weakness in the literature as this is a decisive point in the process of seeking help. If there are factors such as a self-reliant attitude that restrain Indigenous men from seeking help, then this needs to be addressed. Similarly, if there are potential factors that could prompt Indigenous men to seek help, it is necessary to enable these factors in the help seeking process of Indigenous men with mental health problems.

**Step: 3. Deciding to seek help**

Deciding that help is necessary and deciding to seek help are two different entities. Once individuals decide that help is necessary for their mental health problems, it does not automatically lead to a decision to seek help. Multiple factors appear to influence the decision to seek help. These are highlighted in Table 4.

There are several barriers to taking the decision to seek help for a mental health problem. A study of young people who had recognised that they had a problem, reported that their reasons for not obtaining help included, not wanting to admit that something was wrong, fear of the unknown, living alone with no supports to acquire help, stigma in the community or fear of being labelled and negative images of mental illness (Commonwealth of Australia, 2004, p.16). Fear of the condition itself is another factor that inhibits people from deciding to seek help (Thompson, et al., 2004). Moreover Nalder (1987) argues that seeking help could reflect one’s inadequacy and that individuals avoid seeking help because they fear a threat to
their self esteem. Normativeness, which refers to the extent to which others are perceived to share an experience or engage in a particular behaviour (Cialdini & Trost, 1999) is also a known barrier to help seeking. For example, if most of a man’s peers hide their mental health problems it becomes normative for him to do the same. This can take the form of cultural norms as well. In more traditional societies, if cultural norms dissuade men from seeking help for mental and emotional problems, then men tend to adhere to these norms (Addis & Mahalik, 2003).

Table 4: Factors influencing the decision to seek help for a mental health problem in the general population and Aboriginal people

<table>
<thead>
<tr>
<th>Group</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>Not wanting to admit one’s problem</td>
<td>If Idols such as sportsmen and actors promote help seeking for a mental illness</td>
</tr>
<tr>
<td></td>
<td>Fear of the problem, of the unknown and of being labelled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stigma in the community associated with negative images of mental illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need to be normative and follow cultural norms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need for control and self-reliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Associating masculinity with being tough</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concrete barriers (transport, insurance and financial difficulties)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Embarrassment and reluctance to discuss emotional problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distrust of caregivers</td>
<td></td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>Not known</td>
<td>Not known</td>
</tr>
</tbody>
</table>

In particular, the decision to seek help for a mental health problem appears to greatly challenge men. Mansfield, Addis, and Courtenay (2005) have summarised barriers to making the decision to seek help among men into five types. They are:

1. Need for control and self-reliance
2. Minimising problem and resignation
3. Concrete barriers and distrust of caregivers
4. Privacy and
5. Emotional control

The need for control and self-reliance barriers relates to how men’s feeling of control over themselves gets threatened by a clinician’s examination procedure or suggestion of a lifestyle change. The minimising problem and resignation barrier refers to men associating masculinity with the ability to tolerate increasing levels of pain until it becomes unbearable. Concrete barriers refer to problems such as transport, insurance, and financial difficulties. Privacy barriers refer to embarrassment such as personal inhibitions to undergo examination of intimate body parts. Finally, emotional control relates to men’s reluctance to get emotional or talk about their feelings (Mansfield, et al., 2005).

Men’s need to preserve and showcase their masculinity has also been indicated as a significant factor affecting their help-seeking behaviour. Courtenay (2000) argues that the long held cultural belief that men are the strong ones and are less vulnerable than women, is often reinforced by men when they enact behaviour such as risk-taking and playing down illness. He further suggests that masculinities are often constructed in opposition to health beliefs of women. In addition, it is thought that men may portray their hegemonic masculinity by refusing to seek help. Men may also adopt practices that are harmful to their health in order to conform to traditional masculine beliefs (Mahalik, Burns, and Syzdek, 2007).

Facilitators for the decision to seek help are few. The behaviours of popular men (role models) such as sports persons and actors can serve as both facilitators and barriers of help seeking. If popular men are known to openly seek help for their
mental health problem, men are thought to more likely acknowledge help seeking for a mental health problem as the conventional thing to do (Addis & Mahalik, 2003).

**Deciding to seek help among Indigenous people**

Once again, there is little evidence on the decision making process among Aboriginal people although there have been attempts to develop interventions to promote help seeking for suicide (Capp, Deane, & Lambert, 2001). Capp and colleagues (2001) suggest that Aboriginal people could be successfully trained to recognise individuals at risk for suicide and promote help seeking. They conducted the training through a series of one-day workshops in the Shoalhaven region. This type of ‘gatekeeper training’ was also said to empower the Communities where they were conducted. The step of deciding to seek help appears to be significantly influenced by gender. Being men and the male role in mainstream society have a strong impact on deciding to seek help. However, whether this is also true for Aboriginal men is not known.

**Step: 4. Deciding the type of help needed**

Once the decision to seek help is taken, the next step in the general population is deciding the type of help needed. It is now clear that the majority of those who have had a diagnosed mental disorder in the previous twelve months use self management strategies (increased physical or social activity, relaxation and stress management) and support services (such as counselling) (Olesen, et al., 2010). This is not necessarily alarming as a large number of these individuals have less disabling conditions (Andrews, Issakidis, & Carter, 2001) which can be effectively addressed by self-help strategies (Jorm & Griffiths, 2006). Other preferred sources of help are friends and relatives (Oliver, Pearson, Coe, & Gunnell, 2005) or confidants (Riedel-Heller, Matschinger, & Angermeyer, 2005). However, when the severity of symptoms increases, people prefer to use professional help (Jorm,
Griffiths, Christensen, Parslow, & Rodgers, 2004). The factors influencing the decision to seek help from mental health services are listed in Table 5.

**Table 5: Reasons for the general population and Aboriginal people deciding that help from mental health services is needed**

<table>
<thead>
<tr>
<th>Group</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mainstream population</strong></td>
<td>Less severe symptoms</td>
<td>More severe symptoms</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
<td>Higher education status</td>
</tr>
<tr>
<td></td>
<td>Differences between the culture of individual and service</td>
<td>Positive past experiences with services</td>
</tr>
<tr>
<td><strong>Aboriginal people</strong></td>
<td>Differences in culture</td>
<td>High levels of distress</td>
</tr>
<tr>
<td></td>
<td>Lack of awareness of how to access services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fear of being locked up</td>
<td></td>
</tr>
</tbody>
</table>

Some of the reasons why people are not comfortable with accessing professional help include fear of treatment (Deane & Chamberlain, 1994; Kushner & Sher, 1989), discomfort with disclosing personal information to another (Komiya, Good, & Sherrod, 2000; Vogel & Wester, 2003), and stigma (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004). One’s support network can promote or hinder access to professional mental health services. If the support group strongly feels that the problem is simply due to life stresses and that there is no need for formal help, it becomes all the more difficult for individuals to seek professional help. Thus in close knit ethnic minority communities where beliefs do not coincide with the culture of the service providers, health seeking pathways could be restrained from reaching such facilities (Birkel & Reppucci, 1983).

Some studies have also examined the profile of those who are less likely to utilise mental health services. This group has been identified as younger men (aged < 35 years) in a married or de facto relationship (Andrews, et al., 2001; Reavley,
Cvetkovski, Jorm, & Lubman, 2010). Reavley, et al., (2010) suggest that this could be due to both higher rates of substance use disorders and less severe disorders in this group.

The factors that facilitate the decision to seek help from professional mental health services include severity of symptoms, educational status as well as support from family and friends (Saunders, 1993). More severe symptoms, a higher education status and support from family and friends can prompt help seeking from these services. Additionally, positive past experiences can also influence people to choose a particular service provider (Gulliver, et al., 2010). A recent Australia wide survey indicates that those with affective disorders such as depression are more likely to access formal health services (49.7%) than those with anxiety or substance use disorders (22% and 11.1%, respectively) (Australian Institute of Health and Welfare, 2009b).

**Deciding the type of help needed by Aboriginal people**

Several authors have indicated that deciding on the type of help is contingent upon the severity of the mental illness condition that Aboriginal people experience. It has been suggested that Aboriginal people with mental health problems are first managed by the family, failing which the extended family is involved and later the community Elders, if needed (Westerman, 2004). If the situation turns out to be very difficult, the ill person may be referred to the family’s traditional healer through a third person (Vicary & Bishop, 2005). It has also been suggested that in most cases, only those with severe forms of illness who have exhausted the resources of the family and Community and who have high levels of distress reach mainstream services (Briscoe, 2000; Westerman, 2004). Whilst this trend appears to be similar to that in the general population, within Aboriginal communities, this is more serious as Aboriginal people tend to wait until the illness becomes very serious.
It has also been found that Indigenous males (9 percent) are less likely to visit a health professional for their distress than are Indigenous females (14 percent) (Australian Institute of Health and Welfare, 2009a). Even so, one study indicated that Aboriginal youth were not sure how to access these services although they were aware of some of the Koori specific services that were available (Deane, Wilson, Ciarrochi, & Rickwood, 2002). One reason why Aboriginal people do not prefer mental health services is fear of being locked up when admitted to a psychiatric hospital (Eley et al., 2007).

As a result, it has been suggested that Aboriginal people and men in particular do not access western treatment until the problem becomes unbearable for both the individual and the family (Briscoe, 2000; Saunders M, 2003; Vicary & Westerman, 2004). This is also evident in the type of services accessed by Aboriginal people for mental health problems. In Victoria, the most commonly utilised service for a mental health problem by Aboriginal people was the Crisis Assessment and Treatment Team (CATT) with 43 percent of males and 53 percent of females utilising this service (Victorian Government Department of Human Services, 2007).

It is likely therefore, that a substantial number of Aboriginal people with less severe ‘mental health problems’ either endure their illness or adopt some form of coping strategy, while not receiving any kind of professional help. This group represents the unmet need for services.

**Step: 5. Contacting the mental health service**

Once the decision has been taken as to the type of help that one needs for their mental health problem, the next step is to actually obtain that help. While there are several types of help that people seek such as self help strategies and help from
relatives, friends and other influential people in their circle, in this review, only the step of contacting the mental health service will be discussed as that is the focus of this research. The list of factors that facilitate and inhibit people contacting the mental health service is given in Table 6.

Table 6: Factors that inhibit and facilitate the general population and Aboriginal people contacting a mental health service

<table>
<thead>
<tr>
<th>Group</th>
<th>Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>Affordability</td>
<td>Affordability</td>
</tr>
<tr>
<td></td>
<td>Transport</td>
<td>Transport</td>
</tr>
<tr>
<td></td>
<td>Distance</td>
<td>Distance</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>Time</td>
</tr>
<tr>
<td>Aboriginal people</td>
<td>Stigma and shame</td>
<td>(Potential facilitators)</td>
</tr>
<tr>
<td></td>
<td>Lack of trust</td>
<td>Culturally appropriate names for services</td>
</tr>
<tr>
<td></td>
<td>Racism and discrimination</td>
<td>More intermingling with service providers to promote trust</td>
</tr>
<tr>
<td></td>
<td>Gender issues</td>
<td>Employment of Aboriginal staff</td>
</tr>
<tr>
<td></td>
<td>Differences in language and culture</td>
<td>Cross-cultural training for service providers</td>
</tr>
<tr>
<td></td>
<td>Poverty</td>
<td>Displaying Indigenous art and posters</td>
</tr>
<tr>
<td></td>
<td>Lack of round-the-clock services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long waiting times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of transport</td>
<td></td>
</tr>
</tbody>
</table>

Among the general population, once the decision has been taken to access mental health services, the step of actually contacting the service can ensue rather quickly (Saunders, 1993). This step however, is influenced mainly by structural factors such as affordability, transport, distance from the health service and time (Gulliver, et al., 2010; Thompson, et al., 2004). However, in close knit groups such as those in the military and in rural areas, stigma and gossip relating to contacting services is a significant barrier (Boyd, et al., 2011; Iversen, et al., 2011). In addition, fear of being treated differently and harm to one’s career were also reported by military personnel as barriers to contacting mental health services (Iversen, et al., 2011).
Indigenous people contacting the mental health service

As discussed earlier, the most common service accessed by Indigenous men is the CATT service indicating that they are likely to contact a mental health service mostly when they are in a crisis (Victorian Government Department of Human Services, 2007). Among Aboriginal people several factors have been reported to influence their contacting a mental health service. The ‘shame factor’ or stigma is one factor that prevents Indigenous people from accessing mental health services (Briscoe, 2000; Eley, et al., 2007). Corrigan describes stigma as having two components, ‘public’ and ‘self-stigma’ (Corrigan, 2004). He notes that when the public attach a stereotype to individuals with mental illness and proceed to discriminate against them, those who believe they have a mental illness shield themselves from this discrimination by hiding their illness and avoiding visiting mental health services. However, the source of this shame among Indigenous communities is not well understood.

A general lack of trust in mainstream services by the Indigenous community owing to previous experiences of racism and discrimination can draw individuals away from these services (Eley, et al., 2007; Henry, Houston, & Mooney, 2004; McKendrick, 2007; Wenitong, 2002). Racism against Indigenous Australians started with colonialism (Broome, 2005) and continues today (Mellor, 2003). Institutional racism has been described as the ways in which racist beliefs and values have been built into the functioning of institutions in such a way as to discriminate against, control and oppress minority groups (McConnachie, Hollingsworth, & Pettman, 1988). The problem of racism in health care institutions has resulted in a lack of trust by Aboriginal people in white people and in the institutions run by them.
Gender related barriers also deter individuals from contacting services. For instance, Indigenous people are not comfortable talking to those of the opposite sex about their illness (Sheldon, 2001; Wenitong, 2002). Where possible, it is more acceptable for Indigenous people to be assessed by individuals of the same sex (Wenitong, 2002; Westerman, 2004). Moreover, Indigenous men perceive clinics as a ‘woman’s place’ (Wenitong, 2002). Thus gender is another factor that influences this stage of treatment seeking.

Differences in culture, epistemologies, and language can result in making incorrect diagnoses and using practices that are considered offensive (McKendrick, 2007). Indigenous people who use English as a second or third language can find it difficult to understand the language used by service providers (Eley, et al., 2006; Eley, et al., 2007).

Among Indigenous people, poverty is thought to be another barrier to contacting mental health services for a mental illness where people do not have the luxury of taking care of their health needs because they are preoccupied with meeting their basic needs such as food and housing (Commonwealth Department of Health and Aged Care, 2001; Fan, 2007; Mayo, Tsey, & Empowerment Research Team, 2009).

Other factors reported to be barriers to contacting mental health services by Indigenous people include a lack of round-the-clock services (Eley & Hunter, 2006; Salisbury, 1998), long waiting times, problems with Medicare cards (Wenitong, 2002) and a lack of transport, particularly in rural and remote areas where there are great distances to services (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). Poor linkages between different parts of the health system has also been recognised as a barrier to accessing health services by
Indigenous peoples in Australia (Commonwealth Department of Health and Aged Care, 2001).

Factors that facilitate Indigenous people to contact services for their mental health problems have also been highlighted by some. For instance, destigmatising mental health services by using culturally appropriate names for services has been reported to improve acceptance by Indigenous people (Salisbury, 1998). Improving trust in services is another factor that could improve utilisation. Although addressing issues around racism is not straightforward, certain measures have been reported as being useful in rendering the service Indigenous friendly. When service providers interact with the Aboriginal community in a non-professional environment, the latter get to know the former better and this can promote trust in the service (Westerman, 2004). Moreover, Indigenous staff and Aboriginal health workers who are active in their Communities and are employed in mainstream mental health services can act as cultural advisors to non-Indigenous service providers thereby helping to remove misconceptions associated with those services and boosting the confidence of clients (Eley, et al., 2007; McKendrick, et al., 1990b; Nagel & Thompson, 2006; Norris, Parker, Beaver, & Konkelenberg, 2007). Indigenous people look for something ‘to identify with’ in the clinic, and displaying Aboriginal posters and art on the walls makes them feel more comfortable and also promotes trust in the mainstream services (Hayman, White, & Spurling, 2009; Teasdale, et al., 2008).

In Melbourne, (McKendrick, et al., 1990a) reported an increased utilisation of mental health services by Aboriginal people following the development of a mental health network employing, among others, two Aboriginal mental health workers and one Aboriginal research officer. A local Indigenous community consultation unit enabled liaison between the medical staff and the Aboriginal consultants, thus ensuring greater convenience for clients and promoting a strong sense of identity for the
service as being appropriate for Aboriginal people. However, employing Indigenous staff in mental health services can also have certain disadvantages as many communities are small and close knit and Indigenous people might find it difficult to use a service when they are related to the staff (Wenitong, 2002).

The involvement of Community Elders and traditional practitioners in service provision has also been found to be valuable. A senior psychiatric registrar who worked in Central Australia noted that it was helpful to ‘work in parallel’ with Ngangkaris (traditional healers in central Australia) and that they did not ‘undermine’ his work. He further went on to state that ‘the strongest medicine is when white fella and black fella ways are used together’ (Sheldon, 2001, p.438). However, the involvement of Ngangkaris in mental health services is more common in rural areas than in metropolitan services, and such involvement is more on a one-off basis with no clear protocol for regular engagement in place (Fielke, et al., 2009).

Finally, cross-cultural training of service providers on the mental health needs of Indigenous people along with an appreciation of their pre- and post-colonial history and culture is thought to enable better understanding of their Indigenous clients and modify attitudes towards them (Eley, et al., 2007; Social Health Reference Group, 2004). However, for cross-cultural training to be meaningful and not just tokenistic, the Community that is being served needs to be involved to ensure that appropriate protocols are used.

**Summary of help seeking**

The literature on help seeking for a mental health problem has highlighted some key gaps in the literature. In particular, it highlights that very little is known about the help seeking behaviour of Indigenous people and men in particular for a mental health problem. Aboriginal peoples’ concepts of what constitutes a mental health problem,
their process of help seeking and preferences for sources of help are still largely unknown. Unless an understanding of these factors is obtained, specific culturally appropriate strategies for intervention cannot be designed and implemented. This thesis seeks to qualitatively examine these issues.

**Current mental health services available for Indigenous men**

A second focus of this study is the responsiveness of mental health services to the needs of Indigenous men. While the previous section has indicated that factors hindering Indigenous people from contacting these services are manifold, the following explores the various services available for Indigenous people with mental health problems and their perspectives on catering to the needs of Indigenous clients. Issues related to both mainstream mental health services as well as Indigenous focussed services (e.g. ACCHO based services) are outlined.

Until recently, mainstream mental health services were the only available services in Victoria for Indigenous people with mental health problems. The Victorian Mental Health Service for adults (aged 16-64 years) offer services which include crisis management, mobile support and treatment, continuing care, inpatient services and primary mental health and early intervention (Department of Human Services, 2005). Adult mental health services are primarily targeted at people with serious mental disorders resulting in significant disability as well as those with dual diagnosis (with additional drug and alcohol related problems). Those patients presenting to primary care providers especially general practitioners (GPs) and community health services are referred to primary mental health and early intervention teams for more effective interventions (Department of Human Services, 2006).
In Gippsland, any individual can request an appointment for a mental health assessment either for themselves or for someone else by contacting Triage. This service is made available to reduce the time taken for a referral from a GP. In order to improve access to Aboriginal people, the position of an Aboriginal Hospital Liaison Officer (AHLO) has been established at Victorian hospitals to facilitate the delivery of culturally appropriate services to Indigenous people of the region (Department of Human Services, 2008). Area Mental Health Services (AMHS) in Victoria also have a Koori Mental Health Liaison Officer (KMHLO). The role of this person is to assist Aboriginal clients with serious mental disorders to access the service. The KMHLO are also expected to liaise with other services such as GPs and provide cultural training for the AMHS (Victorian Government Department of Human Services, 2007). However, whether these positions fulfil their role for the service and for the Community is not known. The Victorian government's Improving Care for Aboriginal and Torres Strait Islander Patients program publishes annual AHLO reports on the processes and procedures in health services for Indigenous people in Victoria. The latest report notes that very few Indigenous people were being hospitalised for mental illnesses and were mostly being managed by community based services (Department of Human Services, 2007).

Services catering specifically to Indigenous people have also become an area of focus for health planning for Australia, with many such programs getting underway from the year 1998 (Australian National Audit Office, 1998). Aboriginal Community Controlled Health Organisations (ACCHOs) distributed across Australia have been assigned to serve as the hub of all such programs including the mental health service delivery projects. ACCHOs aim to be culturally appropriate, autonomous primary health services initiated, planned and governed by local Aboriginal communities through their elected Aboriginal board of directors (Hunter, et al., 2005). Many ACCHOs employ GPs who provide primary health care with the help of
a multidisciplinary team. However, a recent report on help seeking in the general population by (Jorm & Wright, 2007) suggests that many young people did not perceive GPs as mental health service providers. Whether this is also true for Aboriginal men and the GPs based at the ACCHOs is not known.

Furthermore, (Hunter, 2007) points out that the Social and Emotional Wellbeing (SEWB) model of mental health services that incorporates the strengthening of Community controlled services and the improvement of access to and responsiveness of mental health care is better suited to Indigenous people than the mainstream model of treatment-oriented services. Aboriginal health services adopt this model of care and run SEWB services. Although ACCHOs have succeeded to an extent in circumventing the problems associated with mainstream services, there are new limitations which have emerged. A recent report titled, ‘Evaluation of the Bringing Them Home and Indigenous Mental Health Programs; Final Report’, prepared for the Office of the Aboriginal and Torres Strait Islander Health, indicates that foremost among the limitations of ACCHO based services are:

- The reluctance of Aboriginal clients to talk to non-Aboriginal counsellors,
- The lack of culturally appropriate approaches to service provision,
- Inadequate measures to reduce stigma,
- A large continuing unmet need for services,
- A lack of trained personnel and
- A need for evaluating and monitoring these services (Wilczynski, et al., 2007).

This report was based mostly on the views expressed by service providers across Australia. The opinions of consumers or potential users are limited. Furthermore, the inability of ACCHOs to provide culturally appropriate services for the Communities that they serve calls for a better understanding of what makes services culturally
appropriate. According to Mark Wenitong, a prominent Indigenous GP, appropriate modifications of current mainstream health services could go a long way in improving their utilisation by Indigenous men (Wenitong, 2002).

**Exemplars of collaborative initiatives to design better mental health services for Indigenous people**

There have been several attempts to develop appropriate mental health services for Australia’s Aboriginal people and most of them have identified that building strong relationships with the Aboriginal community is central to developing an effective service (Champion, Franks, & Taylor, 2008; Cooper, et al., 2007). The 1996 National Standards for Mental Health Services, National Mental Health Plan 2003-2008 and The National Strategic Framework for the Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004-2009 have all recommended collaborations between mainstream services and ACCHOs in developing innovative and culturally appropriate services for Aboriginal and Torres Strait Islander people (Australian Health Minister’s Advisory Council’s National Mental Health Working Group, 1996; Australian Health Ministers, 2003; Social Health Reference Group, 2004). There is also a need for the strengthening of ACCHOs through the capacity building of Indigenous communities (Social Health Reference Group, 2004). Although government policies have gone some way towards addressing the unique mental health and SEWB needs of Indigenous people, implementation of these initiatives has been slow, resulting in little improvement in the mental health and wellbeing of Indigenous people over the last decade (Menadue, 2008). Progress is better and more swiftly achieved when there is a successful collaboration between governments, community mental health services and ACCHOs.
The Australian Integrated Mental Health Initiative (AIMHi) is an example of collaboration between Aboriginal organisations, mainstream health services and tertiary educational institutions (Nagel, 2004). Other instances of collaboration in developing appropriate mental health services for Indigenous people have also been documented with substantial success (Eley, et al., 2006; Eley, et al., 2007; Fuller, et al., 2005; Laugharne, Glennen, & Austin, 2002; Teasdale, et al., 2008; Toowoomba District Mental Health Service, 2003). An important pre-requisite for these partnerships is the relationship between key individuals (Fuller, et al., 2005; Menadue, 2008). It has also been suggested that productive research collaborations must be built on ‘sensitivity’, ‘reciprocity’, ‘respect’ and ‘equality’ (National Health and Medical Research Council, 2003; Pyett, Waples-Crowe, & van der Sterren, 2009).

Describing an innovative mental health network and a successful collaborative program between an Aboriginal community and an academic unit in Victoria, McKendrick and colleagues note that effective partnerships need ‘goodwill and a preparedness to work through difficult issues’ (McKendrick, et al., 1990a). Fuller and colleagues point out that establishing and maintaining these partnerships are of prime importance and might warrant employment of individuals to work solely on building and maintaining networks (Fuller, et al., 2005). Waples-Crowe and Pyett describe the elements of a successful partnership between Indigenous communities and non-Indigenous institutions that include valuing each other, building trust, formalising partnerships and providing supportive environments (Waples-Crowe & Pyett, 2005). Furthermore, while reflecting on a research collaboration between an Aboriginal community and a University, Mayo and colleagues state that if the collaboration recognises the Community’s priorities and incorporates the principles of Community consultation, capacity building, transparency and patience among others, the initial scepticism would give way to ‘positive experiences’. They also
reiterate that building such collaborations requires commitment and time (Mayo, et al., 2009).

**Policies on Indigenous mental health services**

National policies also clearly state the need to address the difficulties faced by Indigenous people with mental health problems. The Fourth National Mental Health Plan lists five priority areas for improvement in current services (Commonwealth of Australia, 2009a). Among them, three priority areas namely ‘social inclusion and recovery’, prevention and early intervention and ‘service access, coordination and continuity of care’ are of particular relevance to Indigenous people. The plan calls for a national strategy to reduce stigma associated with mental illness and services as well as implementation of a social and emotional wellbeing framework for Indigenous people. Additionally, to improve understanding and recognition of mental health problems among Indigenous people the plan seeks to implement mental health literacy programmes. Finally, the plan states that access to services needs to be improved by implementing evidence based innovations that promote collaboration with other primary health services. While the plan highlights the need for various strategies to improve mental health literacy, improve recognition of mental health problems, reduce stigma and improve access to services, these cannot be achieved unless there is more evidence on help seeking behaviour of Indigenous people.

In addition, the National Mental Health Policy 2008 calls for linking mental health services with the rest of the health system in order to reduce stigma, improve quality of services and ‘provide services that are close to and respectful of people’s family, community and cultural networks’ (Commonwealth of Australia, 2009b, p.18). The policy also states that currently there is limited evidence as to how to tailor
assessment and treatment of Aboriginal and Torres Strait Islander peoples and highlights the need for more innovative mental health research to improve service delivery. Although these policies recognise cultural differences and thereby the different needs of Indigenous people, on the ground realities with regard to implementation of these policies are quite different (Menadue, 2008).

**Summary of the literature review**

The literature reveals that there are at least five steps in the process of help seeking for a mental illness. While there is some evidence on the factors that influence these decisions for the mainstream population, literature for Indigenous people and men in particular is insufficient.

For instance, with regard to the first help seeking step, no literature is available on facilitators of problem recognition among Indigenous people. In addition, whether or not differences in concepts of mental health and illness affect problem recognition among less traditional Indigenous communities such as those in Gippsland is also not known. There is also no evidence on how Indigenous people decide that help is necessary for a mental health problem. Literature is also sparse on factors that influence Indigenous people to decide to seek help. The decision to seek help for a mental health problem appears to affect men in the general population to a great extent owing to the attitudes commonly encountered in them. Whether these factors affect Indigenous men as well is also not known. While there are several reports that list factors influencing the decision to seek help from mental health services, little is known of whether Indigenous people also access other types of services for their mental health problems. Consequently, the lack of knowledge about Indigenous male help seeking is a considerable weakness in the literature.
Furthermore although several collaborative attempts have been made to improve services for Indigenous people, there continues to be shortcomings in service delivery both from mainstream as well as from ACCHO based mental health services highlighting the need for further investigation. The roles, functions and usefulness of AHLOs have also not yet been evaluated. Finally, the need for further research aimed at developing innovative mental health services that specifically cater to the needs of Aboriginal and Torres Strait Islander peoples has also been espoused by National Policies.

In light of the important gaps in knowledge highlighted above, it was decided to focus this thesis on exploring the help seeking behaviour of Indigenous men with mental health problems and identifying ways to render mental health services more user friendly for Indigenous men. The research question and objectives relating to this focus are listed below.

**Research Question**

What are the factors that facilitate and inhibit help seeking and utilisation of mental health services by Indigenous men with mental health problems in Gippsland?

**Objectives of the study**

1. To examine the factors that influence help seeking by Indigenous men with mental health problems.
2. To identify the factors affecting utilisation of mental health services.
3. To determine the barriers and facilitators to care for Indigenous men with mental disorders.
4. To identify strategies to address and improve access to and utilisation of mental health services by Indigenous men.
Chapter 3

Methodology

Introduction

Initially, this chapter briefly outlines the history of research involving Indigenous people and the subsequent shift in the way research is currently carried out. In keeping with the principles of decolonising methodology, the process of developing the research question is then described. Following this, a case is made for adopting a Qualitative Description design, which is the approach used in this study. Methods of data collection and ethics approval are then described. The chapter ends with descriptions of the process of recruitment of participants and data analysis.

Researching Indigenous populations

Early research involving Australian Indigenous people commenced with anthropological studies that were often intrusive, demeaning, and unethical. Most research did not result in any lasting benefit to the Community (Henry, et al., 2004; Johnstone, 1991; Smith, 1999). As a result, many Aboriginal and Torres Strait Islander people, like Indigenous people elsewhere, have grown to distrust research and researchers (Humphrey, 2001). Although, initially, there were no clear policies and guidelines into the conduct of research involving Australia's Indigenous people, more recently, there has been a paradigm shift in the approach to research (Henry, et al., 2002; Humphrey, 2001; National Health and Medical Research Council, 2003).

Over the last decade, much has changed in the area of Indigenous research. Two reports, “We don't like research” in the year 2000 and “We can like research” some
eight years later, highlight this development (Onemda VicHealth Koori Health Unit, 2008; VicHealth Koori Health Research and Community Development Unit, 2000). In particular, the 2008 report emphasises the need for Indigenous people to initiate and control research that involves them. However, there continues to be many Indigenous communities where Indigenous researchers are unavailable and those Communities are either ill-equipped to initiate research themselves or their interest in research needs to be cultivated (Onemda VicHealth Koori Health Unit, 2008). In such situations, research can still be conducted by building ‘strong partnerships between the Community, ACCHOs, research organisations and researchers’. This has been recommended by the Victorian Aboriginal Community Controlled Health Organisation’s Strategic Directions Report for the Social Determinants of Aboriginal Health Project (Watson, Adams, Fredericks, & Mahoney, 2010, p. 9).

The present research adhered to the guidelines on Ethical Conduct in Aboriginal and Torres Strait Islander Health Research indicated by the Australian National Health and Medical Research Council (NHMRC, 2003). The NHMRC has proposed six guidelines that researchers need to consider during the “conception, design and conduct of research” that involves Indigenous people. They are briefly described as follows:

**Reciprocity** - When research involves Aboriginal and Torres Strait Islander peoples, the researcher needs to ensure that they are included in the planning and implementation of the project as well as demonstrate tangible benefits to the Community in terms of capacity-building, opportunities and outcomes.

**Respect** – Researchers must acknowledge contributions, interests and aspirations of Aboriginal and Torres Strait Islander peoples, acknowledge and affirm the right of
people to have different values and aspirations, and make apparent the consequences of the research at the outset.

**Equality** - Researchers must appreciate the knowledge and wisdom of Aboriginal and Torres Strait Islander peoples and take this into account to avoid misinterpreting data and meaning and cause mistrust. They must also treat all partners as equals and ensure that benefit is shared equally.

**Responsibility** - Researchers must ensure that no harm is done to Aboriginal and Torres Strait Islander peoples or to the things that they value, and ensure that they are accountable to Aboriginal and Torres Strait Islander peoples, their families and Communities in all they do.

**Survival and Protection** - Researchers must be aware of the history of Aboriginal and Torres Strait Islander peoples, respect their social cohesion and cultural distinctiveness.

**Spirit and Integrity** - binds all the above values together. Aboriginal and Torres Strait Islander peoples will look to see if a researcher demonstrates a good spirit and integrity (NHMRC, 2003).

The method in which the current research adopted these guidelines is described in Table 7. The table outlines how the values and ethics guidelines were adhered to at the various stages of this research study. It describes the different stages of the research starting from educating oneself about the history and culture of Aboriginal people (Survival and Protection) right up to the stage of giving back to the Community (Reciprocity). It also illustrates the time taken to achieve each step.
Notably, interviewing of Indigenous participants commenced only at the end of the second year.

**Table 7: Value-based steps followed by the thesis author in engagement with an Aboriginal Community in Gippsland, Victoria**

<table>
<thead>
<tr>
<th>Steps followed</th>
<th>NHMRC Value</th>
<th>Time line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarised myself with Aboriginal History and culture and received training in cultural competence</td>
<td>Survival and Protection</td>
<td>Year 1</td>
</tr>
<tr>
<td>2. Confirmed area of research need by consultation with the Koori community/ Indigenous experts in the field Identified a promoter to introduce me to the Community Obtained support in the form of supervision from an Indigenous and non-Indigenous researcher from VACCHO</td>
<td>Responsibility</td>
<td>Year 1</td>
</tr>
<tr>
<td>3. Identified partners and formalised partnerships with the Indigenous community involved in the research 1. Obtained formal support from RDAC who would support the research 2. Identified and obtained formal support from cultural advisors Applied for and obtained Ethical Clearance for the study</td>
<td>Equality</td>
<td>Year 1</td>
</tr>
<tr>
<td>4. Began process of ‘cultural immersion’ to allow the Community to get to know me</td>
<td>Spirit and Integrity</td>
<td>Year 2</td>
</tr>
<tr>
<td>5. Gradually built trust through informal interactions with the Community (‘learning while working in the community’) Recruited participants for the study using snowball sampling</td>
<td>Respect</td>
<td>Year 3</td>
</tr>
<tr>
<td>6. Gave back to the Community by: 1. Conducting training on ‘Basics of Counselling’ for the SEWB workers 2. Acknowledging participant contributions in publications and presenting them with copies of the work 3. Avoiding misinterpretation of meaning by ‘respondent validation’</td>
<td>Reciprocity and Equality</td>
<td>Year 2, Year 3, and Year 4</td>
</tr>
</tbody>
</table>
Importantly, Table 7 also highlights the considerable time it takes for a non-Indigenous person to familiarise themselves with Aboriginal people, identify partners and build partnerships and to get to know the local culture. It also highlights the need for the Community to get to know the researcher well enough to trust him.

The research was informed in part by the de-colonising methodology proposed by Maori academic Linda Tuhiwai Smith (Smith, 1999). Smith states that ‘Indigenous methodologies tend to approach cultural protocols, values and behaviours as an integral part of methodology’ (Smith, 1999, p. 15). An attempt is made to present the method used in this study from Smith’s perspective. The steps taken in the research process to ensure cultural sensitivity have been described below.

**Early consultations with the Community and identifying cultural advisors**

Authors have stressed the need to begin consultations with the Community involved in the research before the research proposal is developed (Pyett, et al., 2009; Wand & Eades, 2008). One of the supervisors of the study acted as the ‘promoter’ of the research. His role as promoter was significant due to his previous experience as the Regional Coordinator of the SEWB program when he had developed important networks and working relationships with all Aboriginal communities and their respective organisations within the region. The promoter was the key to setting the foundation for the research work. At the outset, he introduced me to the CEO of RDAC and to other significant members of the Koori communities of Morwell, Sale

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7 Midway into the research, there were changes to the supervision arrangements which resulted in the promoter ceasing to be on the supervisory team.
and Bairnsdale, to obtain their support and discuss the logistics of the proposed study (Hendersen, Simmons, Bourke, & Muir, 2002). While discussing the proposed research with Community members, an Elder poignantly remarked, ‘What you do is important but how you do it is more important.’

It is frequently suggested that the research be overseen by a steering committee consisting of Aboriginal Elders and other significant members of the Community (Hendersen, et al., 2002; Pyett, et al., 2009). When asked for advice regarding a steering committee, the CEO of RDAC suggested that it would be most feasible to have cultural advisors (CAs) who could be contacted individually for advice and guidance. Accordingly, one CA was chosen from each of the three key service areas in the region. All three agreed to support the study by recruiting participants and providing guidance on engagement with the Community. Later, formal letters of support were received from each of them (See Appendix 1).

Involving the Community in validating the focus of research

I initially met with key Indigenous persons involved in mental health and social and emotional wellbeing (SEWB) from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). In addition to supporting the proposal, one Indigenous and one non-Indigenous researcher from VACCHO agreed to co-supervise the research. An early outcome of these discussions was the decision that being a man, it would be culturally appropriate for me to confine the research to Indigenous men.

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8 Midway into the research, there were changes to the supervision arrangements which resulted in these individuals ceasing to be on the supervisory team.
Furthermore, mental health services in the study area are coordinated by a single regional hospital through community mental health centres spread across the region and the then director of psychiatric services at the regional hospital was also keen on supporting the research. I also consulted with the Regional Coordinator of the SEWB and Stolen Generations Projects of RDAC and the staff, all of whom emphasised that utilisation of services was poor and expressed interest in supporting research into rendering these services more culturally appropriate for their Communities. Involving Indigenous people and their organisations in research planning demonstrates Reciprocity, which is one of the core values identified by Australian Indigenous people (National Health and Medical Research Council, 2003). Thus the focus of research was endorsed by all stakeholders.

**Research methodology**

Patton (2002) states that it is primarily the purpose of a study that informs its design and how the results must be analysed. Similarly, Kitto and colleagues emphasise the ‘soundness of fit’ between the research questions, the study’s aims, and the choice of methods (Kitto, Chesters, & Grbich, 2008). Qualitative studies usually ask the questions, ‘what’, ‘how’ or ‘why’ of a phenomenon rather than ‘how many’ or ‘how much’ (Green & Thorogood, 2004, p.5). Studies of this type seek to discover more about a phenomenon rather than measure it. Furthermore, qualitative research can fill the gaps in traditional epidemiological knowledge, shed light on the perceptions of those providing and receiving health services and thereby can ultimately sensitise care givers to patients’ views and needs (Green & Thorogood, 2004). The methodology employed in this study was qualitative since the research question seeks to explore the perceptions and experiences of participants.
Qualitative Description

Qualitative description (QD) is a relatively recent method of naturalistic inquiry which aims to “present a rich, straight description of an experience or an event” (Neergaard, Olesen, Andersen, & Sondergaard, 2010, p.2). In QD studies, participants are asked to describe events in their own words and to suggest ways of improving outcomes or changing behaviours (Sullivan-Bolyai, Bova, & Harper, 2005). Unlike in other qualitative designs such as phenomenology, ethnography and grounded theory, where the researcher interprets the said word within a context, in QD, the researcher stays close to the data (Sandelowski, 2000). This is particularly useful in disadvantaged populations where it is not difficult to misinterpret quotations (Sullivan-Bolyai, et al., 2005).

The QD design is useful in obtaining information that is particularly relevant to service providers and policy makers and is typically valuable in answering questions such as “What reasons do people have for using or not using a service or procedure? Who uses a service and when do they use it?” (Sandelowski, 2000, p.337). Although, some qualitative texts and reviewers tend not to recognise QD as a valid research methodology, others suggest that QD is a useful tool particularly for researchers working to reduce health disparities among vulnerable groups (Sullivan-Bolyai, et al., 2005).

QD is advantageous when conducting research aimed at improving interventions or decreasing health care barriers for disadvantaged populations (Sullivan-Bolyai, et al., 2005). The design therefore presents rich information that may be grounded in cultural and environmental contexts. This makes research using this approach understandable not only to those experiencing health disparities but also to
clinicians and administrators who are responsible for reducing those disparities. QD has also been used elsewhere in studies of a similar nature (Scharer, 2002).

Theoretical framework

This study is based on the framework that there are several stages to help seeking for a mental illness (Saunders, 1993) and that people experience barriers and/or enablers at all stages (See Chapter 2). However, the literature on Indigenous men’s help seeking is sparse and details of barriers and enablers are not well established. Although QD lacks a strong theoretical basis and is underpinned by the work of others in the field, its findings can pave the way for future theory-based research (Neergaard, et al., 2010).

Selection of participants

Generally QD is amenable to any purposeful sampling technique although maximum variation sampling is most preferred (Sandelowski, 2000). In this study, there were two distinct groups whose perceptions and experiences were being studied. They were Koori participants (including men, carers and SEW workers) on one hand and mainstream mental health professionals on the other. While Snowball sampling was used for Koori participants, purposeful sampling was used for the mental health professionals.

Snowball or chain sampling is an approach to locate information-rich cases and difficult-to-access participants through ‘well-situated people’ who are familiar with these cases to start with and then by asking more and more people who else to talk to. Thus the snowball gets larger and larger as the number of cases increases (Kitto, et al., 2008; Patton, 2002). While carrying out research among Aboriginal peoples who can be hard to reach, it is very important to develop relationships with individuals, families and the Community (Vicary & Bishop, 2005). Snowball sampling was therefore considered to be an appropriate method of sampling while conducting
research among this population. CAs consented to publicise the research study to their peers and assist with recruitment of participants. ‘Maximum variation sampling’ which provides for as many differences as possible in the experiences being studied was chosen for the study (Liamputtong & Ezzy, 2005). This was to obtain a comprehensive understanding of the experiences and perceptions of Koori men and carers from the region.

Two assumptions were made while considering snowball sampling among the Koori population. First, it was assumed that mental illness was not uncommon among the Koori population and that even if the sampling strategy did not directly target those with a mental illness, the process would include them as well. Second, it was assumed that being a close knit Community, most men would know a friend or relative with a mental illness and share commonly held perceptions about the illness even if they did not have an illness themselves. Therefore the sampling technique did not directly target those with a mental illness. Moreover, the study also intended to unpack men’s commonly held perceptions, attitudes and practices with regard to the different types of mental illness in the Community thereby seeking to obtain a maximum variation sample. Given the difficulty inherent in conducting Indigenous research by a non-Indigenous researcher, it was initially decided to interview five men from each of the towns of Morwell, Sale and Bairnsdale and five carers totalling 20 Indigenous men and carers.

Service providers were sampled by purposeful sampling. Purposeful, purposive or judgement sampling focuses on identifying information-rich cases (Patton, 2002). ‘Studying information-rich cases yields insights and in-depth understanding rather than empirical generalisations’ (Patton, 2002, p. 230).
**Data collection**

Both face-to-face semi-structured interviews and focus group discussions were used for data collection. Semi-structured interviews were conducted with Indigenous men and carers as well as with specific mental health care providers. Interviews were guided by a set of topics which formed the stem around which the discussion took place and is the most popular type of interview method used to capture details of respondent’s experiences (Hansen, 2006, p. 69). These interviews:

> are conducted on the basis of a loose structure consisting of open ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail (Britten, 1995, p. 252)

Broad topics based on the objectives of the research and available literature formed the initial framework of analysis (See Table 8.).

**Table 8: Topic list for interviews with Indigenous men and carers**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Concepts of mental illness</td>
<td>When do men feel that they are mentally unwell?</td>
</tr>
<tr>
<td>2. Help seeking for a mental health problem</td>
<td>What do men usually do when they feel that they have a mental health problem?</td>
</tr>
<tr>
<td>3. Experiences with mainstream services and ACCHOs</td>
<td>What do men feel about mainstream mental health services and the ACCHO based services?</td>
</tr>
<tr>
<td>4. Perceptions of barriers to utilisation</td>
<td>Are there any difficulties in accessing these services?</td>
</tr>
<tr>
<td>5. Improving mainstream services Improving ACCHO based services</td>
<td>How can these services be made more acceptable for Koori men?</td>
</tr>
</tbody>
</table>

Respondents were encouraged to talk about issues that they felt were important even if it did not conform to the set topics. Interview questions for Koori men were
directed away from them so as to avoid ‘putting them on the spot’ (Westerman, 2010). When questions particularly of a personal or sensitive nature are directed to Indigenous people requiring them to give a direct answer, it can cause them shame (Tamisari & Milmilany, 2003). Interviews with Koori participants took place in various locations such as their home, office, University premises or the ACCHO. Although all participants were given the explanatory statement or were given the option of it being read to them, most men said that it was not necessary as I was referred by a trusted and respected person. Furthermore, prior to commencing the study, I was advised that Koori men were not comfortable signing any official documents. However, only one Koori man refused to sign the consent form preferring vocal consent (that was recorded).

Focus group discussions were conducted with teams of mental health professionals. Managers of each team suggested that in order to make best use of time (given their busy schedule) a focus group discussion was preferred. The basic argument for using focus groups as a data collection method as opposed to interviews with individuals is that it enables participants to share their experiences and opinions that may not easily be accessible through an interview (Liamputtong & Ezzy, 2005). Focus groups work better when participants share similar social and cultural backgrounds. Even if the group shares similar experiences but not similar backgrounds, the focus group can still have good outcomes as participants will feel that others in the group will understand them (Liamputtong & Ezzy, 2005). Mental health staff were also offered the option of a one-on-one interview with me if they felt it necessary.

Focus groups were conducted in the seminar room of the service facility where the staff usually assembled for team meetings. This was not only convenient for them but also ensured that discussions stayed within the room (Willis, Green, Daly,
Williamson, & Bandyopadhay, 2009). Each team consisted of mental health nurses, case managers, social workers and the service manager. Initial topics for the focus groups were developed from the objectives of the study (See table 9).

Table 9: Topics for focus groups / interviews with mental health professionals and administrators of mental health services

<table>
<thead>
<tr>
<th>Topics</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequency of utilisation by Indigenous men</td>
<td>How many Indigenous men have you had as clients since the last 6 months?</td>
</tr>
<tr>
<td>2. Differences in engagement with Koori men</td>
<td>How is working with a Koori man different from working with a non-Indigenous man?</td>
</tr>
<tr>
<td>3. Cultural specificity of services</td>
<td>Do you think this service is culturally sensitive? Why do you think so?</td>
</tr>
<tr>
<td>4. Successes and shortcomings of the current system</td>
<td>What are the strengths of the current service delivery system for Indigenous men? What are the weaknesses of the system?</td>
</tr>
<tr>
<td>5. Ways of overcoming shortcomings</td>
<td>How do you think this service can be made better for Koori men?</td>
</tr>
</tbody>
</table>

Ethics approval

Ethics approval was obtained from Monash University's Standing Committee on Ethics in Research involving Humans and from Latrobe Regional Hospital's Human Research Ethics Committee (See Appendix 2). While approving the study, the Chair of the Standing Committee stated in an email, 'The Committee has asked me to convey their appreciation to all researchers, but particularly the PhD student, for the sensitivity and compassion shown when preparing this exceptionally well thought out application.' (See Appendix 3).
Recruitment of Koori participants

Hammond (2010) states that it can be quite difficult for people to initiate projects in an Indigenous community if they are not from that Community. This phenomenon was clearly evident in this study. Although CAs had initially agreed to introduce me to potential participants, the process took a long time. Recruitment mostly took place during Community gatherings, where Koori men surrounded by their own people felt comfortable enough to talk to outsiders. Such gatherings were infrequent. They usually occurred during NAIDOC week celebrations (National Aboriginal and Islander Day Observance Committee week is celebrated in July every year ‘to celebrate the history, culture and achievements of Aboriginal and Torres Strait Islander people’) and Reconciliation walks (organised by Koori Communities during Reconciliation Week celebrated between the 27th of May and the 3rd of June every year to contemplate on reconciliation between Indigenous and non-Indigenous people in Australia (National NAIDOC committee, 2010; Reconciliation Australia, 2010). The process of recruitment at some of these events is discussed below. Community members who had enough time to get to know me were more forthcoming to participate than others.

One CA suggested that in order to recruit participants for the study, I needed to attend Community gatherings. This process has been described as ‘learning while working in the community’ where the researcher participates in Community life and events in order to develop social skills and understanding of the Community’s culture (Pyett, et al., 2009). Accordingly, I attended every get-together of the local Aboriginal Community that I was invited to and made multiple courtesy calls to the different services run by RDAC. The promoter initially accompanied me on these visits until I felt comfortable going on my own.
The process of engaging with the Community was slow and occasionally bumpy. In the second year of the research, I was invited to the flag raising ceremony for NAIDOC celebrations at the local Koori meeting place. Having arrived at the venue early and noticing that my CA had not yet arrived, I walked up to a group of Koori men and introduced myself. In no time, all of them departed save one who then said to me,

“You see all of them walked away? You never walk into a group of Koori men and talk to them unless you know them. Stand aside and wait until they call you. Koori people will never talk to you unless they know you. Remember this always’.

To ensure that my interview questions were sensitive and appropriate, I conducted practice interviews with my CAs. Although the three CAs had approved of the explanatory statement prepared specifically for Indigenous participants, practice interviews helped them to better understand what the process was about and gave them more confidence in introducing me to other men (See Appendix 4). During the course of the next 12 months, I attended many funerals, had multiple meetings with my CAs and recruited a few more men for the study. On the invitation of RDAC, I also conducted a basic course on counselling for their SEWB and Drug and Alcohol workers which was well received. As part of the research, I had incorporated artwork of a local Koori artist in a poster for which I won a prize at the Higher Degree by Research Student Poster Exhibition, 2008 (See Appendix 5). A copy of the poster was formally presented to the artist in the presence of my CA and another Elder. With each of these activities I attempted to demonstrate the core values of *Reciprocity, Respect and Equality* (National Health and Medical Research Council, 2003).
An invitation to a men’s golf day outing in the second year had provided a promising opportunity for me to meet and recruit men for the study. However, heavy rain led to its cancellation and it was another twelve months before the event was rescheduled and I was able to attend. By this time, I had developed a friendship with my cultural advisor. Since I had not played golf before, I was given my first lessons by a Community Elder and playing as part of a team I was touched by their generosity, patience and encouragement. Following the game as I was about to leave, my cultural advisor invited me to the cultural program scheduled for the following day. He said, ‘Come if you can. You are part of the Community now and you know that the doors are always open’. Another sign of my acceptance was when men held their hand up to lock mine in a ‘Koori handshake’, which I learnt from an Elder.

I made regular phone calls to my CAs to enquire about potential participants. During one such call, my CA asked me to drive over to a local park where a Koori expo was taking place. There was a gathering of members of the Community there and he introduced me to a few men who agreed to be interviewed. On another occasion, I was invited to participate in the Reconciliation walk. At the end of the walk, while people were having their barbecue lunch, my cultural advisor introduced me to a group of men who readily agreed to participate giving me their phone numbers. One of the men was a local Elder. At the end of the interview with this Elder which was conducted later, he suggested that he would accompany me to some houses and talk to people whom he knew. He said that his presence would enable the men to feel comfortable talking about their problems. Two men were recruited that way. Three others were not home that day. One male Elder who agreed to participate was unable to keep his appointments on 3 occasions because of deaths and funerals.
By the end of two and a half years into the research, a total of 13 Indigenous men and two carers had been recruited. Due to time constraints, recruitment had to be discontinued at this point. Formal interviews with two CAs were also included in the data as they were men from the Community and shared similar experiences to other participants. Most participants were from the one Community (17 kms from where the University department is located). Recruitment was less successful in the two Communities which were further from the University (81 and 149 kms away) and where people did not get enough time to be acquainted with me. As part of giving back to the Community, I conducted a 3-hour education session on ‘the basics of Counselling’ for the SEW workers.

**Recruitment of service providers**

Staff of the SEW services were recruited through the CEO of Ramahyuck District Aboriginal Corporation. Recruitment of mental health professionals took place in three stages. At the outset, I met with the then director of mental health services and described my study to him. On his advice I met with the managers of the different services, the staff of which I had wished to recruit for the study. After obtaining their consent a nurse educator coordinated recruitment of staff of the four services, viz: community mental health services of Bairnsdale, Sale and the Latrobe Valley as well as the Acute Psychiatric care unit.

There is only one Koori Mental Health Liaison Officer (KMHLO) for the Gippsland region who is responsible for overseeing all Indigenous clients of the mental health services. This position is different from that of a Koori Hospital Liaison Officer (KHLO) who is present in most Victorian hospitals. In spite of a telephone request by the manager of mental health services as well as a one to one meeting, the KMHLO refused to participate stating that the research involved men and so it was not appropriate for her to be involved. The Koori Hospital Liaison Officer of one of the
hospitals in Gippsland was recruited through the staff of the community mental health services in that region who recommended her to be interviewed as she had played a significant role in the care of Aboriginal men who had been admitted to that hospital with a mental illness. As noted earlier, there were 17 Koori participants and 28 staff from the mental health services. Table 10 indicates a complete list of participants, their characteristics and method of data collection.

Table 10: List of Indigenous and non-Indigenous participants

<table>
<thead>
<tr>
<th>Type of participant</th>
<th>No.</th>
<th>Method of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koori men - clients of mental health services (KM)</td>
<td>5</td>
<td>Interview</td>
</tr>
<tr>
<td>Koori men - non-clients (KM)</td>
<td>5</td>
<td>Interview</td>
</tr>
<tr>
<td>Koori Carers (KC)</td>
<td>2</td>
<td>Interview</td>
</tr>
<tr>
<td>Koori men – CAs (KMc)</td>
<td>2</td>
<td>Interview</td>
</tr>
<tr>
<td>Koori Hospital Liaison Officer</td>
<td>1</td>
<td>Interview</td>
</tr>
<tr>
<td>SEWB workers (2 Koori)</td>
<td>3</td>
<td>Interview</td>
</tr>
<tr>
<td>Mental Health Nurse</td>
<td>1</td>
<td>Interview</td>
</tr>
<tr>
<td>Private Psychologist affiliated to RDAC (Female)</td>
<td>1</td>
<td>Interview</td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data analysis

All interviews and focus groups were recorded with a digital voice recorder and transcribed verbatim. A data spreadsheet was then developed in Microsoft Excel with the list of initial topics on the vertical axis and list of interviews and focus groups on the horizontal axis. Data from each transcript that matched the research topics on the data spread sheet were then copied and pasted into the corresponding cells.
Data that did not match a pre-existing topic but that was considered relevant to the study was included under a separate theme. Once all data was entered into the spreadsheet, data from each topic was extracted separately and analysed further. Data that formed new themes and subthemes were grouped together and arranged in a logical sequence. This process was repeated until no new themes emerged. In keeping with the principles of QD, numbers have been used where relevant to describe the frequency of data. This has been referred to as a “quasi-statistical analysis style” (Miller & Crabtree, 1992).
Findings

Introduction

A total of thirteen themes emanated from the data. These have been categorised into three results chapters that follow (chapters four, five and six). Each of these chapters has been titled according to the broad topic covered by the set of themes described in it. Chapter four titled ‘Obstacles faced by Koori men in seeking help for a mental illness’ focuses on four themes. Chapter five titled, ‘Mainstream services for Koori men: The mismatch’ focuses on three themes and chapter six titled, ‘Future Directions: Improving men’s help seeking and service utilisation’ focuses on six themes. Details of the chapters, the themes that they focus on and the source of data for each of the themes are given in Table 11.

Furthermore, each results chapter is presented first by an introduction to the themes covered in the chapter followed by explorations of each theme and finally a summary of the findings. Themes are presented initially with a definition which is followed by quotes of interviewees’ voices that embellish and detail them. Subthemes that emerge from each of the themes are then reconciled with the larger theme.
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Owing to the sensitivity of the topic, Koori men have responded in different ways. Sometimes, they have spoken on behalf of the Community and at other times, on behalf of themselves. This is due in part to the nature of the questions which were more directed away from them rather than specifically to each individual. This was
done in keeping with the convention that Indigenous men are not comfortable with being put on the spot and being asked direct questions. Another possible reason for men speaking on behalf of the Community is an Indigenous tradition of belonging to a collective rather than being responsible for oneself alone.
This chapter focuses upon responses associated with Indigenous males and their help seeking. The four themes relating to this topic include the difficulty recognising mental illness, men’s reluctance to talk about mental illness, their unwillingness to contact services and employment of alternate coping strategies.

You don’t realise that you’ve got one, you know…:Recognising mental illness

This theme focuses on men’s inability to recognise the presence of a mental illness. Many men (n=9) indicated that the awareness of what constitutes a mental illness was poor in the Community. The lack of awareness can also refer to men’s inability to recognise that the symptoms that they are experiencing are indeed related to a mental illness, as shown with the following representative quotes from men.

Well, I might have a problem right now and I’m not aware of it, because of the amount of stress I’m under – Kurnai Elder (Journal notes)

You don’t realise that you’ve got one, you know ... So until somebody actually points it out to you, you can go through your whole life not knowing that you’ve got a social emotional problem. – KMc1

Others suggested that people often confused mental illness with other common medical conditions. For example, one man said:
There’s people walking around and thinking that they might be just cases of something like high blood pressure or cholesterol or a drug and alcohol problem when really it’s associated with a mental illness. – KMc2

Men indicated that some individuals were at a higher risk than others of not being aware of issues around mental health and illness. For instance, one man said:

A lot of Indigenous people that are mostly men that live alone just really keep to themselves. So they don’t really know. – KM7

There were also other situations where men could find it difficult to recognise their symptoms as this man said:

Some of them [family] members might actually be going through that themselves. They might be cousins or relations of that person. So … you’re not going to know. – KMc1

Another important factor thought to contribute to this lack of understanding was the language used to describe the different illnesses. This was outlined in the following conversation with one of the men.

KM6: I think that the language itself, these sort of words we don’t use in our daily lives, in our family.

Researcher: Like what?

KM6: Depression and anxiety... So a lot of people don’t identify the labels.

Researcher: What are the words that equate to this?

KM6: Oh, I’m stressing out... so these medical terms, just going over the top, or they’re misinterpreting or they’re simplifying [it so] much that it doesn’t even mean that you’re depressed, “No one’s pressing me down, aey?”, you see what I mean?

The paucity of programs to improve awareness of mental health and illness in the Community was indicated as another factor. Participants suggested that unlike
drugs and alcohol, the subject of mental illness was hardly ever discussed in the Community. A Koori SEW worker said:

I don’t think a lot of people know, I think it’s got to be more talked about within the Community... there’s a lot of talk about drugs, a lot of ICE and stuff like that, but you don’t see much about say ... bi-polar or ... depression or schizophrenia. – SEW1

While some men described the difficulty understanding mainstream terminology there were others who suggested that traditional terms, used within the Community might add to the difficulty in recognising mental disorders. However, two Elders - one male and one female had different understandings of a traditional term that was used in the Community.

When we were growing up as an Aboriginal child, we used to use the word Dembin, so if someone wasn’t acting like normal, like everybody else we would call them Dembin ... and a lot of people didn’t think too much of it, but now thinking back, looking back at it, I think they must have been a mental health issue, and so, to us it was acceptable that someone was a little bit different, and a little bit Dembin, but we didn’t sort of relate it to a mental illness, ... . – KHLO (Female Elder)

In the Kurnai language you’re Dembin. You too Dembin you – you’re silly in the head, you’re gone, You’re mental – You’re a mental case – just like that – you need to be put away in [the psychiatric hospital]. – KM1 (Male Elder)

Although most men indicated that awareness regarding mental illness was poor in the Community, there were others who shared their understanding of mental illness. This understanding related to difficulty in communication and disturbed behaviour. Three men demonstrated their understanding of what a mental illness is:

I speak to them when they are sober and they drift off or talk vague, you know...Then I know there’s something wrong with them. - KM6
They are not mentally well when they lose it a lot for no reason at all – KM2

When they walk out of their house, slam the door, using abusive language, [continuously for] 5 or 10 or 15 minutes or so, walking out the gateway slamming the gate with the dog being in the yard or into somebody else’s house using very abusive language … and that sort of stuff and that carries on for about 10 or 15 minutes – KC2

Difficulties in recognition of mental health problems and mental illness were therefore a key barrier to help seeking by Koori men.

**With Koori men, they don’t like to talk: Disclosing one’s illness**

Although recognition of the problem was a challenge, men also reiterated that even when they did recognise that they had a problem, they had difficulty disclosing it. Ten men described this difficulty in admitting one’s illness.

Well, I reckon half of them know it [that they have a mental illness] but they don’t want to admit it. – KM6

We do have mental illness problems throughout the Aboriginal community but ... they keep it well hidden ... They keep it well hidden...They don’t want to share it with anyone - KC2

A lot of Koori people won’t admit that they have a mental health problem ... - KM 10

A lot of Koori men don’t want to ask for help you know what I mean, they’ve got to be forced in help. – SEW1

An older man who had been diagnosed with depression some years ago said that he did not discuss his problems with others, an issue that he believed cut across age groups.

A lot of people don’t want to open up like that. I know I don’t. I haven’t. I’ve never done it. I’ve never gotten help at all ... Yeah I don’t think I’m
really speaking to people either, about problems. I reckon a lot of people, like young people, would probably be like that too. – KM4

Other men reinforced this view.

*With Koori men they don’t like to talk. – KM8*

Even when accompanied by a familiar Indigenous worker, men have difficulty opening up to professionals. An SEW worker described this from his experience of accompanying a client to an assessment for counselling.

*I went to an assessment with a client and I pretty much answered all the questions... And this was just for the assessment, so what’s he going to be like when he gets to a counsellor? This was just the interview, you know and I’d go, “Is that right?” and he’d say, “Yes.” But that was all he was saying. It was like, “Come on, you need to open up!” and so on the way home I was talking to him about what happens at counsellors. – SEW2*

Although men did not like talking about their problems to anyone, others indicated that they discuss such problems with close friends whom they trust. One man highlighted the case of his friend who had a mental health problem.

*He doesn’t like talking about it, talks about it with me because he’s a good mate of mine and we’ll have a drink about it... – KM3*

Although men had trouble opening up and talking about their problems, there were times when peers or others would suspect a problem either during a conversation or if they observed some behaviour that was uncharacteristic of that person. However when brought to their notice, men would evade the issue. An SEW worker described this.

*They just say, ‘I’ll be alright. I’ll be alright.’ then you find out a few months later that they’re trying to commit suicide and stuff. – SEW1*

Some covered up their symptoms with substance abuse.
Some people do cover it up with the alcohol, and they're covering it up not thinking they've got a mental illness either, thinking, “Oh, something's just wrong with me”.

Self disclosure was problematic for many men, because, according to them, Koori men needed to safeguard their role in society and fulfil their role as provider. Several men and the Koori Hospital Liaison Officer (KHLO) were of this opinion.

They're [Koori men] supposed to be strong, supposed to be able to do things, if something’s wrong, then they can’t provide. It’s like then they don’t feel adequate, they can’t provide for their family, you know... - KM3

Yeah and [our] pride, yeah... Well, being black fellas, we’re strong and yeah we don’t think we need to go to see someone – KM6

I think it comes down to just probably being them; “I don’t need help... just go and be a man” and stuff. “You’ve got to be strong”. It’s always been in our culture to be strong... be a strong Koori man... – SEW1

Umm ... it’s more of a “toughen up. Get over it”, you know. – KM2

For a man to let somebody else know they're not coping, it's like putting himself down. - KHLO

Some of the men were clear that this view of manhood clearly impeded asking for help.

You’ve got the machoisms, “You’ve got to be a man, you’ve [got to] work hard, you’ve got to sweat...You can’t cry” - yeah all this, “You can’t afford to be sick” - KM1

“Don’t be a wuss, get over it, everybody has that sort of drama ... get over it” and sometimes it’s a little bit worse than they realise and by the time they realise it’s a bit too late. – KM2

One man extended these arguments, when he referred to reacting against mainstream perceptions of Koori men.
“I don't want to get perceived as the poor Indigenous person that's always sick, that's always wanting help from somewhere”, you know? so that's the mental[ity] ... - KM7

Similarly, stigma provided another major barrier to disclosing one's mental illness.

Five men (n=5) described their shame talking about their problems.

It has a bit of a stigma attached to it, as in like, mental health means that people think there's something wrong with you, up in your head I mean, and that's true to a degree but I think people are scared of that so if anyone's got an issue that fits in the area of mental health, they sort of don't talk about it.
– KM3

Stigma was especially problematic in small communities as this man (a client of mental health services) said.

Whether they're ashamed or because people talk when you're in a small Community... They have that stigma. It's pretty hard you know. – KM8

One man referred to the traditional way in which one might be ostracised from the tribe because of mental illness, with another reported that this still occurred today.

There's all sorts of things that used to happen years ago with someone who was mentally unwell...they'd ostracise them from the tribe. It's not so much these days, but there's still that idea that maybe people in the Community will find out and react the wrong way, but I suppose that goes for anyone in any society but Aboriginal fellas find it more sort of ... [difficult] yeah.- KM2

It's awfully hard to talk about yeah ... and as soon as people say, “Oh you've got a mental health issue!” there's an automatic barrier come up and say, “Hey this guy is a little bit freaky” and they kind of put you in that little category of black sheep over there. – KM10

Past experiences with government agencies proved another powerful detriment to disclosing mental illness.
Nowadays, it’s become the norm not to talk about problems because if there are problems then someone will step in, like government ... you know, take you away... because families are strong, right? ... Family is everything [to] you, and to be taken away from your family is like dying, basically. - KM3

Likewise, another man described how, others had difficulty accepting authority from mainstream service providers.

[The reason] a lot of Indigenous people don't accept stuff is because they’ve got their guard up a lot because they feel like they've been robbed in the past or they feel like something’s been taken off them without them having any chance to stick up for themselves ... so when they get told that they have got mental emotional problems then it’s very hard for them to adjust and to accept that that’s the problem.- KM7

Apart from difficulties in recognition, a reluctance to disclose one’s mental health problems was also considered as another barrier to help seeking by Koori men.

I'm not going to do that shame job: Reluctance to contact services

Building on the previous themes, respondents indicated that there were barriers to contacting mental health services even when men were able to recognise their problems and disclosing it to others. Contacting and attending psychiatric services was considered by eight men to be a “shame job”.

If a Koori has to go to psych services, it’s a shame job. That’s not Koori way.- Journal notes – Ex-administrator of a Koori sobering up centre

Yeah, they think it’s a shame job [to go to a service?]... - KC2

‘I’m not going to do that shame job [go to a service].’... - KM6

Additionally, mental health services were considered unfamiliar and alien as this man said.
One of the reasons why people don’t go is because they don’t understand it. It goes over their head, yeah, they’re big words … too scary, not going to go there … hmmm… - KM6

Further emphasising the foreignness of services, one man pointed out that according to past Koori experiences, hospitals, the key providers for mental health services, were considered places where people went to die, rather than be treated.

[In the] early days, you went to hospital to die, not to get better. That was the track record for our people, so therefore those are the stories that we’re getting back home. So the next generation [says], “I’m not going to that hospital, I’m not going there to die, I’ll die here.” They’ve made a conscious decision to stay home and die, rather than dying in a foreign place, in foreign hands. That trust factor … We need some scores on the board, from that service. – KM6

Four men highlighted the importance of being able to trust mainstream services.

There’s quite a lot of trust that’s needed – but until you get it – they probably won’t talk to you as much as you’d hope. – KM2

Furthermore, negative opinions of services prevailed due to a perceived lack of positive outcomes over time. One male Elder said.

Nothing’s changed over a long period of time so it’s hard to change people’s views on these particular places unless they feel confident with the workers and the organisations that they’re actually involved with. - KMc2

Government agencies and that kind of thing where they’ve been promised things before and they’ve been mishandled and there’s never seemed to have been a lot of votes for governments in Aboriginal affairs. There’s a lack of trust. There’s a lack of trust that’s always going to be there. - KMc2
As a result of collective negative experiences with government services, it was suggested that Koori men took longer to trust mental health professionals than non-Indigenous people did. A Koori SEW worker expressed this when he said:

*I think it takes a bit longer for a Koori person to trust someone, to get to know someone than say non-Indigenous [people] because of what happened to our people during the history of this great country we live in.* – SEW1

Experiences of racism were also highlighted as a factor that dissuaded men from accessing mainstream mental health services. One man who had recently started accessing services from the city felt that racist attitudes were more prevalent in the regional areas than in the urban services.

*KM8: Well, they’d rather not go to the mainstream services. They rather be dealt with by their own people than go to the wider community.*

*Q: Why do you think that is?*

*KM8: Because they are uncomfortable. And they are uncomfortable because of the attitudes that the white people have. If they are in the city, no worries, but down in the regional areas, it’s a different ball game altogether. Always has been. It’s a very racist country, Australia.*

A carer, whose children were long term clients of the mental health services, noted that while discrimination was present, this had reduced over time, in part because of the presence of overseas trained doctors.

*They say that they are being treated equally but that’s not the case. I’ve seen racial discrimination at the hospital as well. But now since I’ve come to know the people and they’ve come to know me and who I am and what I’m about with my children, I’ve a better understanding and relationship too. That would be only because of the other Indian and [African] doctors.* – KC1

Another client of mental health services said that he was not listened to and that service providers were more interested in getting rid of him.
When you’re up there telling them what you’re feeling inside, they don’t really listen. That’s what I perceive. They ain’t really listening to what you’ve got to say. It’s just, “You’ve got your doctor’s certificate you’ve got there, you’ve got your medication? Ok, Go away...” – KM9

There were also those who felt that there was no racism, particularly from respondents who worked in mainstream organisations.

I’m not saying it doesn’t happen but I’m saying it rarely happens – KM7

I’ve never had no problems with it and I work in a mainstream organisation myself and I’ve been here well, for about six years and even when I first started I didn’t think that there was any ill feelings. – KMc1

The fear that services could not maintain confidentiality was suggested as a key issue when accessing services. One man said:

Whatever service they’d access, someone they know is going to be working there and someone’s going to find out that this fella was in, even though they have that Hippocratic oath or something, people still talk... “I saw so and so in here the other day”. - KM 2

Similarly, several men said that there was a risk of being labelled “mental” if they contacted psychiatric services.

“I’m not going to go to that place, then be labelled”, if you go there, you’ll be labelled as mental or something. – KM6

People don’t like to be labelled or even [be] talked about, ‘Oh he’s going to the mental health clinics’, or ‘He’s going off to the [mental hospital here]’. - KM3

People will tell you, “You're going to [the mental hospital] because you're a nut.” So you wouldn’t deal with those issues. You wouldn’t talk about it. You wouldn’t discuss it with anybody, even your family. So, yeah, it’s a hard one
really, ... the stigma of being labelled a [mental] or having something to do with mental health. – KM3

This feeling of shame also arose when discussing personal problems with service providers such as doctors. A client of services mentioned this.

I know a lot of blokes now...Koori men who won’t go a doctor because they don’t wanna spurt out their feelings ...because they feel ashamed. It’s all about the shameness of it. You see?... - KM8

When men did not have family support, accessing services was also more problematic.

Wow, all that’s [family ties] sort of broken down – the whole thing – the family cycle is broken down ...Today there’s no [family] structure, so therefore there’s no roles and responsibilities... - KM1

... a good friend of mine who’s here locally, moves from house to house ... he went through the same sort of problems that I had - marriage breakdown, loss of income, house, everything and he just wanders ... So basically he just, jumps from couch to couch ... - KM3

In comparison, the involvement of family and other supportive social networks positively influenced help seeking.

I had a lot of blokes there. It was the family supporting me and friends ... they pushed that, so it happened fairly quickly. It wasn’t me doing it. It was other people that were pushing all this to make it happen, virtually fast. So it was good for me. And then, I had others, through my medical centre. My doctor pushed it as well, which was great. So I, and family were saying, “Go and do it, Go and do it. We’ll do this, we’ll do that... it was good.” – KM3

The poor reputation of Psychiatric services was therefore another detriment to help seeking by Koori men.
Just stay and have another drink: Alternate ways of coping

Koori respondents suggested that they used alcohol, and at times (but less frequently) other substances to cope with symptoms of mental illness. Eight men indicated that alcohol was used to deal with mental health problems.

_They believe that they can overcome [mental illness] by using alcohol or maybe using drugs or maybe using needles, injecting themselves with needles that are in the Community these days._ – KC2

_A lot of the guys around my age have a problem with alcohol and me included… and that was to hide your feelings. Hide how you felt, and sometimes it wasn’t to hide, it was just to deal with, you know, “I don’t want to deal with that today. So I get pissed”_ – KM3

_It’s another form of trying to lose yourself…getting out of that problem._ - KM8

_Turn to substance abuse because that's the easy way, it's the escape path, it's the exit door that's closest to you..._ - KM7

Substance abuse was not only a way of coping but demonstrative of ‘giving up’ as this man said:

_If you have a [mental illness] it’s the end of your whole life. They give up. It's the end … that's the feeling that Indigenous people have. That's why they turn to substance abuse … self esteem is a very big issue with Indigenous people as well._ – KM7

Men also related alcoholism to their loss of purpose in life.

_That’s why you see a lot of Koori men take to the alcohol or the drugs...because what’s their purpose in life? They’ve got none now. That’s the big issue. That’s the real issue._ – KM8
If you have a look at their purpose in life, that’s really been gone since settlement... – SEW2

One man linked ‘giving up’ with loss of culture and language.

*Our culture is just gone....dead and gone mate... and so is our language. That’s why we’ve got a lot of our people drinking and drugging on.... Once your culture’s gone brother, that’s it....we’re lost. Our culture is gone, our language is gone. Black fella gone now...* - KM8

Shifts in gender roles exacerbated this loss of identity.

*The wife’s out there earning the money and all that which caused a lot of arguments because the males have lost their role.* – SEW2

*The women are the ones that are educated nowadays; the women are the ones with the good jobs. The men sit at home. The kids go to school. What are they going to do? Drink!* – SEW2

*It's easier for a woman to get a job than it is for a man ... it just happens. So our men feel worthless...* - KHLO

Some men reported that that there was a general feeling that symptoms of depression were not serious, and that a drink or a smoke would make them feel better.

*Yeah that’s what a lot of people say. “... You’ll be right. Just stay and have another drink. Let’s go and get another smoke.”* – SEW1

*They sort of brush it off. They go, “You’ll be right, you know, a couple of days”... or, “Have a drink, Have a charge; you’ll be right.”* – KM6

Role modelling was a key aspect of taking on drinking as a coping strategy.

*It's affecting other people that's around them, bringing them down with the people that are having them – they're depressed, they got to have a drink, the*
other person is looking, seeing the Elder depressed having a drink, they're going to be depressed having a drink. – KM7

Koori men coped with their problems by using alcohol and other substances due to the several factors that precluded them from seeking help.

Summary

In this chapter, men indicated that the first barrier to seeking help was a lack of awareness about mental illness. This they highlighted was due to solitary living conditions of men, having other family members with similar symptoms, the mainstream use of technical terms coupled with the community’s use of traditional terms and the lack of discussion within the Community on mental health problems.

Nevertheless, even when they did have concerns, cultural and peer pressure dissuaded them from talking about it. This attitude of not wanting to talk about their problems is so ingrained in Koori men that despite encouragement from familiar figures, they found it difficult to open up. The difficulty in disclosing one’s illness was also attributed to the fear of being separated from their families by government agencies.

Furthermore, psychiatric services had a poor reputation among Koori men who referred to it as a ‘shame job’. The reluctance to contact services were due to issues arising from the service itself (for example, racism, unfamiliarity and problems with confidentiality) as well as issues more related to Koori men, including lack of family support, negative perceptions and a lack of trust.

While men experienced several barriers to seeking help for a mental illness, they coped with their problems using alcohol and other substances. Alcohol seemed to
be the panacea for all the stressors that men experienced. These included day to
day stressors, loss of self esteem and culture as well as loss of their position in
society to the women. Clearly, barriers faced by Koori men to seek help for a mental
illness and mental health problems are multiple and form a complex web of factors.
Chapter 5

Mainstream services for Koori men: The mismatch

[Koori men] interpret our presence as a threat not help... as potential to take their children away from them.

This chapter outlines the themes relating to the mismatch between mental health services and Koori men’s needs. There are three themes described below. These include gaining entry into the services, barriers to engaging Koori men, and staffing problems. Unlike the responses in the previous chapter which were derived mostly from men’s voices, the themes in this chapter emerged from responses of both Koori men and service staff.

Koori people...they want that fixed there and then: Barriers to gaining entry into the service

Both men and service providers clearly stated that there were inherent characteristics within mental health services that made it difficult for Koori men to gain entry into the system. These included having to wait for appointments.

Koori people... they want that fixed there and then when they realise that they do have a mental health issue or a drug and alcohol issue. If they can't get a service straight away, it gives them time to think about it, calm down or get some other dependency and go away from it and numb the pain that they're in for the time being. – KM10

Clients obviously need things straight away. They can’t sort of wait for a week or something like that because the issue was right at hand. - KMc2
Indigenous people do not respond well to that [waiting]. Quite often they expect an immediate respite from the crisis – SEW3

Waiting times were excessive to participants. This was expressed both by Koori men and non-Indigenous social workers:

Now how many months do I have to wait to actually see them? I mean it’s not straight away. You’ve got to be booked in and you’ve got to wait a couple of months before you do actually see them. – KM8

The wait, yeah. And that’s a real problem. You’ve got somebody in Accident and Emergency, who’s contemplative – you want to link them in as soon as you can. If you’ve got a four week wait, then you’re dead in the water. Sometimes you can get an appointment within the next couple of days, but as a rule, it’s a four week wait and you’ve lost your contemplative period. – Social worker 2

Other SEW staff concurred with these statements when they suggested:

Emergency has a poor reputation with all. It’s just the services are overworked and psychiatric patients are low down on the level anyways… psychiatric Indigenous patients are way below. They’ll be noticeably down there and with drug and alcohol, dual diagnosis patients whether they are Indigenous or not will still get very low level of treatment because they are not seen as a high priority. – SEW3

In defence, however, some staff reported:

The numbers are just too large in the general community here to assure that you could see someone once a month for instance. It could be 6 or 8 weeks before you can see a psychiatrist, perhaps even longer. – FGD CMHS3

Inclusion criteria were also problematic.

It might be that somebody is responding to a grief and loss thing and thinking about self harm. Now, you know that this is kind of a natural reaction. I
don’t refer them through because I don’t think that our service would accept that referral…. our intake criteria are exclusion criteria. But then, you’ve got to sit with the worry that this person might act on their ideation, without any documentation, without them seeing our psychiatrist or our doctors... - Mental health nurse

Workforce capacity was yet another factor in trying to address the mental health needs of Koori men, particularly for diagnoses such as co-morbidity (dual diagnosis).

Those with dual diagnosis are difficult and people find it hard to work with difficult patients. SEW3

Most of our clients have dual diagnosis. So you have to acknowledge that as part of the service. – SEW3

The first mismatch between service provision and the needs of Koori men was the difficulty in gaining entry to the services.

They interpret our presence as a threat not help: Barriers to engaging Koori men

Once men had overcome the hurdle of gaining entry into the service, the next challenge was in meaningful engagement. One of the impediments to engagement with Koori men was the difficulty faced by staff to gain their trust.

They don’t trust us whites or the mainstream, and look, I understand why... - Mental Health Nurse

You have to allow time to develop a therapeutic relationship before you worry too much about dealing out some therapy. – SEW3

M: I find it takes a lot longer to get trust with them. – FGD CMHS 1

Similarly, staff raised issues around child protection and authority.
[Koori clients] interpret our presence as a threat not help... as potential to take their children away from them. FGD CMHS 2

There’s also an intimidating factor... The perception is that we have more power when we’re talking to them, than what we do, but that perception intimidates Koori people to a greater extent than a non-Koori person. – FGD CMHS1

Mental health nurses and case managers also indicated that working with men indoors or in closed spaces were other deterrents to engagement.

M: They can’t talk – they definitely can’t talk in an inside environment.

F: They like to sit outside and talk to you. - FGD CMHS2

I think it’s where you [meet them] again. If we’re doing it in a sterile environment like this, I think that that Indigenous person’s anxiety would be through the roof. – Mental Health Nurse

Some staff highlighted language and non verbal difficulties.

Probably them understanding me... I think because the language is a bit different. – FGD CMHS 1

Where you and I sit here we’ll make strong eye contact in the majority of cases, but most Koori don’t have direct eye contact. They’ll look somewhere else... You know, if a psychiatrist is doing that to an Indigenous person, they get overwhelmed and anxious, and they’ll tell the psychiatrist anything. It doesn’t matter whether it’s right or wrong. – Mental Health Nurse

Engaging men was essential in order to have a meaningful, effective relationship.

One SEW worker stated:

There’s a very long history there of masking symptoms and covering and protecting themselves from non-Indigenous people and they are very good at it. I’ve seen people who are very mentally unwell, be able to mask the symptoms so well that they can fool the best psychiatrists and do it well. The
Some staff described situations when Koori men hid their symptoms from clinicians, with dire consequences. A KHLO described this.

*We had a client down at the hospital. He convinced them that he was well, and I was with them on that day, and the guy that was seeing him said to his wife, “There's nothing wrong with him. You just don't want him home” and she goes, “Well, that's not the case.” So she brought him home. She had no choice because they released him from hospital. That night he tried to hang himself... the belt broke... he took all the medication that they'd given him from the hospital and was in intensive care for 3 days. This is the problem that she had to deal with. – KHLO*

Other staff also suggested that continuity of care with Koori clients was a challenge as they were frequently unable to keep their appointments.

*M: They tend not to keep appointments. They tend to have a different view of time and dates and things like that. It tends to be very much impulsive type of work with [those that] I've met at least. You can make an appointment next week but they usually won’t turn up. - FGD CMHS1*

*F: Sometimes it's a bit of an impulsive thing. It would be that they just happen to be passing and pop in. So it's difficult to keep them...Compliance is a problem. – FGD CMHS3*

*F: There's an inability to keep scheduled appointments and work in a structured planned way and so it's more a reactive thing. FGD CMHS 1*

Some staff suggested that continuity of care was a problem because of the multitude of issues facing many Koori men.

*F: I think there’s just so many issues in the families that it actually prevents the continuity of care. FGD CMHS 1*
Mental health staff suggested that many Koori men did not always disclose all the facts and this hampered assessment.

*M: A lot of things are unsaid - FGD CMHS1*

Others indicated that they overcame this problem by involving the family in care.

*M: I might see his extended family a couple of times a week, who were just as important to give me information about how he was going, because he wouldn’t explain things himself too well. He wouldn’t articulate it. So you often rely on other family members to report… - FGD CMHS 2*

Involving the family in care was also useful when locating clients was hard.

*F: They can live in between different households… they’ve got their residence, but they could be anywhere in that group. So we have to talk to different members of the family to find them. - FGD CMHS 3*

Maintaining confidentiality was also a challenge for some case managers and a breach in confidentiality threatened the therapeutic relationship.

*F: Sometimes you can have a good rapport with a family member and get all the information, but if you maybe mentioned to someone else in the Community that that person does get along with you– that’s it – you’ve just blown the respect – “What are you doing talking to them? If you talk to them again, don’t come around here.” So you have to be very sensitive about what’s going on in the Community… - FGD CMHS 2*

On the other hand, when clients were convinced of a staff member’s ability to maintain confidentiality, it certainly improved help seeking.

*It goes back to that confidentiality- “No I don’t want to see [Jane]. I don’t want to deal with anyone. Just yourself, thanks.” They see that I’m not aligned to any family. – Mental Health Nurse*
Another mismatch between services delivery and men’s needs therefore related to issues with engagement.

**There’s no one there that’s their mob: Staffing problems**

Limitations in staffing patterns also contributed to the mismatch between service provision and men’s needs. Both men and staff highlighted this. Staff emphasised client dissatisfaction with frequent changes in their care provider.

> Clients will be swapped to case managers. They might have assessed that person in crisis; got them over the hurdle; things are going on well; they might have been working with them for six months, and all of a sudden another case manager comes along. And you will find the clients will say to you, “I’m sick of telling them my story, I’m just sick of it”. And that’s where you miss out. – Social worker 2

However, this was inevitable given the scarcity of mental health staff in rural services.

> ... they’re doing the best that they can with the limited resources they have. – Social worker 1

Men however, pointed to the lack of Koori staff in services.

> They don’t want to access services because there are no Kooris over there. There should be Kooris staffed over there in mental health services or in the hospital in general to understand us. - KC1

> Depending [on] what services they go into they’re usually not faced with anyone that they know. There’s no one there that’s their mob... – KM2

They explained how the presence of Koori staff could improve engagement.
They can talk more freely, more openly. I feel more comfortable talking to another Koori man than talking to a white person or a person from another background. – KM8

However, men also cautioned that having someone from the Community at the mental health service also had its drawbacks.

Everybody talks. Nothing is quicker than the Koori Telegraph (laughing) and it’s good in a way, but it’s bad in a way too, because they know that this lad’s going to say something maybe ... and it could be anything. – KM2

But that can have its downfalls as well. That person that they might go to might be an uncle or a cousin, and you know, they might feel like the Koori worker might obviously talk to a parent or to somebody or might let something slip when they’re around a family function. There are a lot of issues around that confidentiality stuff that would tear somebody away from that. – KMc1

The Koori Mental Health Liaison Officer (KMHLO) is an example of a Koori worker in the service. However, mental health staff indicated that there were some difficulties with this arrangement as well.

It has happened on occasion that [we] of course always ask permission for [the KMHLO] to be involved, but sometimes people have got really upset because she’s not the right mob and they don’t want to have anything to do with her. – FGD CMHS1

M: I wouldn’t always mention [her name] first up because it can often blow up in your face, but just mention that name... that might be it; you’ve just lost a person, “If you deal with them, I don’t want anything else to do with you”. – CMHS FGD 2

If they're going to employ liaison workers then they need to be from the right clan. They need to be from the Gunnai Kurnai tribe and the current one we
have isn’t. That immediately puts barriers up against her ability to work in the Community. – FGD CMHS1

Other staffing problems related to the coordination of services.

If they go to the hospital, the hospital is supposed to notify the Koori [Mental Health] Liaison Officer...doesn’t always happen...– SEW3

We have a person who works 5 days a week, and I wouldn’t even know how to contact [this person]. There isn’t a flyer or a poster that is marketing this position and the role of this person, how to access this person, when to access them... I can see that’s a huge issue for the unit here that there isn’t a process for that to occur. People come through the unit and don’t get followed up.- Staff of psychiatric inpatient ward

A limited number of KMHLOs was also highlighted as a limitation of the service.

Male: There's one person for the whole region.

Female: It seems to be fairly ineffective to have one person for the whole region. – FGD CMHS2

Summary

The mismatch between Koori men’s needs and service provision appeared to be present at each stage of service provision and served as a deterrent to utilisation of mental health services by Koori men. To begin with, stringent triage criteria pushed away many men in need of services. Once admitted to a service, the extended waiting periods and their difficult to treat illnesses further delayed treatment. Moreover, barriers to engagement due to men’s continuing lack of trust in the services, differences in communication styles and cultural differences in provision of care contributed to this mismatch. Finally, a pervasive lack of staff, inadequate Koori workers and the presence of Koori workers who did not cater to the needs of Koori clients dissuaded men from contacting services.
Chapter 6

Future Directions: Improving men’s help seeking and service utilisation

I think the services have to go out to these Communities - not [the other way round].

The final results chapter outlines how current practices can be modified to improve help seeking and service utilisation of Koori men in Gippsland. This consists of 6 themes and has been described under two headings. The first relates to improving help seeking by men and the second focuses on improving acceptability of services for Koori men. Sub themes that emerged from each of the six themes have also been explored below.

Improving help seeking by Koori men

Koori participants provided two solutions to the problems presented in chapter four (Obstacles in seeking help). They include improving mental health awareness and empowering men to disclose their problems and talk about it. The theme relating to improving awareness highlights Koori respondents views on the ‘what’, ‘when’ and ‘how’ to improve mental health awareness among Koori men and the Community in general. This is outlined below.

Let them know that there’s support out there for them: Improving mental health awareness among the Community

An important theme was the need to improve mental health awareness among the men. Twelve Koori respondents including men, and staff indicated the need to improve awareness on mental illness. One carer emphasised that it was necessary for the topic to be formally addressed by the Community and its organisations. A carer who was an Elder and board member of the ACCHO said:
By sitting down and talking and putting it on an agenda to talk about...What is mental illness and what is not mental illness – KC2

Another man (Elder) went further to elucidate what was needed by Koori men.

What [we] need is proper education, proper workshops where people are getting down to the nitty gritty of it, and they're getting supported of how to get through it. – KM1

Others suggested that it be organised as awareness days where the Community could get together.

Having awareness days...and make it into a Community day. – KM6

Men also suggested that schools be included in such programmes.

It's got to be enforced into the schools so that there’s more awareness of the young fellas knowing about it. – KM8

It needs to be tackled at an early age. – you’d have to educate young Indigenous men ... so I’m guessing at a high school level before substance abuse becomes a problem... - KM7

Health awareness programmes needed to be conducted on a regular basis.

Those programmes need to start and keep running monthly or every 2 months or something like that, so, it would make people understand what mental health is all about.- KHLO

Men also indicated that it was necessary to destigmatise awareness programmes by including mental health within the broader spectrum of men’s health.

Make it more of ‘men’s health issues’. Don't have [just] mental health. Saying mental means that ‘you're nuts’. If you say it's just a health issue then you can blend it in. - KM7
Issues around drugs and alcohol were also suggested as being important components of awareness programmes.

There are the two big key issues around here – drugs and alcohol – I think you’ve got to combat that to help people with mental illnesses too. – SEW1

The importance of raising awareness about what services could offer, was also highlighted by men.

Creating awareness on what services are out there, you know... - KMc1

Let them know that there’s support out there for them... - KM6

We need to have more awareness within the local Community saying, “Look these are our social emotional workers across the region.” Making sure that the Community is aware of who their particular person is within that Community. If you got that particular knowledge, well a lot of Community at least know who they’ve got to go to. - KMc2

Men emphasised that messages needed to be culturally sensitive and reflect a positive image of men.

That’s got to be embedded [within] the cultural understanding. So you have both. So you have the medical term and blend that in the cultural way. [That] has more of an understanding. – KM7

[Use] culturally appropriate stuff like, “Be strong and smart. It’s culturally okay to talk to another man about your problems.” or something like that... – KM7

We need to be able to have some process where we’re instilling in them that it’s not a shame job ... mental illness is a process like any other sickness, that there is help available and that there are resources [available for them]. – KMc2
Koori men and SEW staff also suggested that Community involvement was important in such programmes as their involvement would generate discussions within the Community particularly when Elders were involved.

*Getting Community to be involved in things like this... you know, it opens their eyes up and gets them talking about some of the issues in our Community and I think this is important and I think this is 50 years overdue.* - KMc1

*Get Elders in or get some people from the local Community in to talk.* – SEW1

Men also suggested ways of promoting such awareness programmes and increasing participation.

*I’d go out and see them. I’d go to their places and I’d tell them that I need them to be a part of this mental illness awareness program and put on a lunch or something for them and bring them along... not just sort of send a letter out to them ... That’s not the way it should work.* - KC2

*If people do not come to [you], well then, you go to them. Go to the people...* - KM6

*Chuck a BBQ. Something to do – you've got to empower it.* – KM7

Improving awareness was therefore considered an important pre-requisite to improving help seeking among Koori men.

*It's okay ... you're not less of a man for it...: Empowering men to disclose their problems*

Apart from improving awareness, there was also a need to empower men to disclose their problems and seek help. Koori men agreed that it was first necessary for men to own up to their problems.
The men need to stand up and start talking about their own problems health wise. – KM10

They also indicated that reassurance was crucial.

“You just admit that you’ve got a problem, bro. It’s okay. Yeah it’s okay to be crook. you’re not less of a man for it” – KM2

Some men felt that men would be able to better acknowledge their problems in a closely knit group such as a men’s group.

I think the men’s group needs to become closer and tighter. – KM6

I think that we need to sit down out underneath a tree or round a campfire and just talk. KM10

A non-judgemental approach and a non-threatening environment was essential.

Have people who want to work in mental health or just in general health come and sit down and talk to us and listen to us and how we feel ... and just acknowledge some of the things that’s gone on and so on. – KM10

Making services more acceptable

Koori respondents and service staff identified various strategies to make services more acceptable to Koori men. These strategies which are described under themes included building confidence in services, developing relationships with the Community, making services flexible and strengthening the role of the Koori Mental Health Liaison Officer (KMHLO). Each of the themes is discussed below.

If they don’t know you then [they] won’t talk to you, really! : Building men’s confidence in services

Building confidence in services was said to be a key requirement to improve utilisation by Koori men.

Well, first and foremost, people need to be confident in the services. – KM3
Men suggested several ways in which their confidence in mental health services could be built. Obtaining support of the Elders was essential in establishing confidence.

*If [the Elders] could be seen using the service, as saying that it’s okay, hopefully that will pass along down the line a bit too.* – KM2

Other men suggested that a visit to the services could be organised for the men’s groups. This could serve to break the ice and generate familiarity with services and service providers.

*We can make a day where we all go to the services and you know, go for everything, like psych services, everything, and get checkups and there’s not enough of that with the men’s group. Make a day of it. You can have a bit of a yarn to a counsellor and you know you can sit there; it doesn’t matter if it’s 2 minutes or 5 minutes. You sit down; have a yarn ... that’s breaking the ice for them. They’d think, “Oh, I’ve got to come see this fella, he’s alright, he’s on my level, he could help me.”* – KM6

Men also suggested that the presence of more Koori mental health workers would enable clients to better identify with the service.

*Indigenous faces at the desk welcoming people ... Indigenous workers ... that makes it culturally appropriate ... that's the connection ... it tackles identity and culture and all those sorts of things* – KM7

*Have more Koori people, even if they weren’t someone I’d spoken to before, it would be nice to be able to speak to one ... could revert back to the way we talk, we don’t have the best of English, but we understand each other. It’s just a comfort thing, yeah I feel more comfortable with my own kind than I do with others.* – KM2

Having artwork and posters that men could identify with helped them to feel more comfortable.
Well, if you go to a hospital and you walk in there, they've got the paintings that don't culturally connect with Indigenous [people]. They have just an odd picture of a boat on the wall... the colours are all the same - pastel colours. but you would have been into the Co-op... you see how that would be set out, how it had the pictures and the colours. – KM7

You look at a [Koori] painting and you think of your home land back here where there is serenity and peace and quiet. – KM9

If they go in there and they see a Koori poster or there's a painting on the wall, just something like that, they can look around and they’ll go, “Oh, this is Koori friendly so I'm willing to stay here.” - KHLO

Similarly, according to one Elder, Koori people felt more confident about services when posters had Koori faces on them.

Have posters about mental health stuff, with Koori faces, because all the stuff that you see is all white faces, so it's sort of thinking, “Okay, that's only for the white people” but, there only needs to be one Aboriginal person in amongst that photo. Then, they’ll think, “Oh well, that's for everybody”. So... yeah, they're much happier. - KHLO

Still others suggested having a Koori place that catered to cultural needs.

We need a fireplace there. A place to identify... we need somewhere where we can sit, listen to them birds and see the fire, so that would be a start. Now there’s somewhere friendly, culturally appropriate to sit and feel comfortable. Sitting in the waiting room is not always culturally appropriate. – KM1

I think the services have to go out to these Communities: Developing relationships with the Community

Service staff indicated that building relationships with Koori men was a crucial way in which services could be made more acceptable to them.
The first thing would be about building those relationships, fostering them, and nurturing them. – Mental health nurse

Just knowledge about the people, the tribe, the place, the families yeah just stuff like that, just a lot of knowledge of the local [Community]. – SEW1

It’s like anything. If they don’t know you then [they] won’t talk to you; really! They think, “Who are you? What do you want?” even if you’re Koori ... Seriously! – KM3

Other staff pointed out that relationships could be built by regular visits to the Community.

It’s about getting people there on a regular basis, so their faces become familiar. – Mental health nurse

I think the services have to go out to these Communities - not [the other way round]. – Social worker 2

Staff could meet with Community members on different occasions.

People need to know who they are. People need to see them. So they need to be out in the Community. They need to be around, even if it’s for just general chit chat ... even if it’s just dropping in and having a cup of coffee that’s fine. So yeah, you need to be more proactive in Community. – KM3

To get people to obviously establish a relationship with anybody, you need to be out there at Community events. – KMc1

Apart from networking with the Community, some staff suggested that it was also necessary to network with other Koori agencies.

M: I think we can be more active in getting out and making ourselves known to other services and other agencies and the Indigenous Community in general, other than brochures and posters about mental illness. Sitting down and talking goes a lot further. – FGD CMHS3
Service staff who had built networks with the Koori Community reported positive outcomes:

\[ M: \text{One of the best days I had was at NADOC week 2 years ago. Me and [Bill] got invited to the Koori Men's Golf Day over at Morwell, I met so many fellas from the Community and it was like we were introduced as “This is the first time we’ve ever had anyone from mental health services come to our group. So they’re there to talk to you.” and all the boys went, “Haa, good on you fellas!” They gave us a gift and we had a great day. – FGD CMHS 2} \]

Relationships can be built between the workers and the Community, as can be seen with this worker here.

\[ He has been so successful that he was invited to join the family and the Aboriginal community on their annual bus trip down to the football to see the Indigenous teams play Essendon. And he actually declined because he thought that would be stepping over the professional line, but he was very chuffed that the family thought so highly of him that they wanted him to come and enjoy the day with them. – FGD CMHS3 \]

However, this same worker had to work on his relationship.

\[ That all came out of a hell of a lot of issues that he did wrong, but also, an awful lot of stuff he did right, and them seeing that each time he was prepared to acknowledge that he’d got it wrong, and they were prepared to forgive him but also, help him understand what they were offended about - FGD CMHS 3 \]

Other staff supported the need to have the right attitude in order to develop good relationships with Koori clients, families and the Community at large.

\[ We have to change our own attitudes. And if we change our own attitudes, then I think people see that, and then, that might create some change for them as well. – Social worker 1 \]
Similarly, a respectful attitude could overcome many setbacks. While mistakes could be made during the relationship building process, an attitude of respect and openness was required to overcome them.

*You have to be respectful. And I think, if they understand [that] you’re being respectful, and even if you make mistakes, you’re forgiven and they know you’re trying. So, that in itself shows that you have that respect and you’re willing to learn from whatever you’ve said or done wrong, and continue on.* – Social worker 2

Building relationships was not only seen by staff as possible but highly valuable in working with Koori men at crisis periods.

*I got called in one evening – a young Koori male down there quite drunk and raising all hell, assaulting nurses...police were having difficulty holding him and containing him – out of all that I was called in to come down and do an assessment and I got down there and I walked into the room and this young fella looked at me – “Hey [Rob], mate” - End of the assaults; end of the swearing; sat down, had a couple of cups of coffee; sat with him for 3-4 hours, sobered him up, took him home to his grandmother’s – no problems.* – FGD CMHS 3

Both men and mental health staff stressed the importance of building relationships with the Community in order to improve service utilisation.

**We have to shift our thinking about how we do our work: Enhancing flexibility of services**

For services to be more acceptable to men, they need to be tailored to suit men’s needs. Staff admitted that services need to function differently if they were to meet the needs of Koori men.

*People say we shouldn’t do any different for Indigenous people. But we have to.* – RCSEW
Male: We have to shift our thinking about how we do our work. - FGD CMHS2

Male: I think ... you have to break the rules of our engagement to actually be able to engage in the ways that Koori people feel comfortable with. - FGD CMHS2

In response to the earlier obstacle regarding location of interviews, some staff suggested:

Male: Having the ability to be more mobile and not expecting people to come into an office space or clinic, to be able to meet them where they are at, whether it’s in their Community, or at the Koori TAFE and other places.... – FGD CMHS

Do it at home. Do it within the Community. People will feel much more comfortable. They will give you much more honest answers, you know. – Mental Health Nurse

However, one case manager cautioned:

Female: That’s a thing too about access and looking after people is the flexibility of the service as well. Case managers as a rule don’t have that much flexibility – I mean you can’t – we’ve got on our books 11 case managers, we’ve got over 300 clients. – FGD CMHS 2

Specific changes focused on involving family members, when working with Koori men.

Male: Now that’s been our experience is that, you have to include other family members. – FGD CMHS 2

That’s how Indigenous people operate, you cannot just work with the individual on their own, you have to include the rest of the family, ... because they're the people who are providing the care, and they're the people we have to negotiate with. – Social worker1
Making services flexible was therefore another pre-requisite to rendering services more acceptable to Koori men.

**A far more active role for that person in the Community: Strengthening the role of the Koori Mental Health Liaison Officer**

The regional mental health service employs a Koori Mental Health Liaison Officer to help cater to the needs of Indigenous clients. Since many of the respondents did not know of the existence of the Koori Mental Health Liaison Officer for the region despite the position being in existence for many years, they were asked about the role that they envisaged for the position. Several respondents agreed that the KMHLO could play a significant role in improving client’s confidence in the mainstream service. They indicated that the KMHLO had a duty to rebuild trust in the system and make Koori clients feel more comfortable and cared for in the service as this man said.

> These liaison officers play a vital and pivotal role in making sure that their clients feel comfortable and ...there’s a lot of pressure on the liaison officers to rebuild the trust ... KMc2

An Elder who is a Koori Hospital Liaison Officer from another town supported this view when she said,

> The Koori Liaison Officer’s job is to make it comfortable for Aboriginal people to come into hospitals and to let them know that we’re there, that we’re looking after the Elders, the youngest, the light skinned children, the Torres Strait Islanders. - KHLO

A carer said that the KMHLO had to be someone whom people could easily get along with.

> I think it’s a matter of having the right person to have that relationship with. – KC2
Another carer emphasised the need for the KMHLO to work in the Community as well.

_They want the computers and those skills... but I reckon they also should have somebody who would work with the Community...somebody who is approachable as well._ – KC1

Other men and carers supported the view that the KMHLO had to interact more with the community.

_Well I would like [that person] to come down to the grassroots level really._ - KC2

_The capabilities that are most important is the communication with the local Community._ – KMc2

This interaction was necessary because the KMHLO needed to have a good understanding of the culture and traditions of the Community in order to be effective. Service providers were of the same view.

_Probably a far more active role for that person in the Community would be helpful._ – FGD CMHS1

Both Koori respondents and service staff indicated that there was a need for more KMHLOs for the region.

_And there shouldn’t be just the one. There should be a couple of them over there out in the Community going to our houses. That’s what I mean by support._ – KC1

_Probably an expansion of that department to have a few workers._ – FGD CMHS1

_We need more Koori liaison workers within mental health, and I think we need a team of them._ – Social Worker 2
One man suggested that for this reason, it was not helpful to fill the position with someone who did not know the local Community.

One thing they have to know is the culture and understanding of the Community around this area. So it’s no good getting someone from Queensland coming down here and trying to help down here because it’s just no go. They’re not going to understand at all. – KM7

A KHLO from a neighbouring town who was from the Community that she served said that being from and knowing the Community was her greatest asset.

I know the Community, and I think knowing the Community is the biggest strength of them all. - KHLO

She indicated that knowing the Community well was an advantage when mental health clients were not being truthful.

If you’ve got a mental health client, and you know the Community, you know where he’s coming from, you know his background, you know his family, you know basically what's happened to him over the years. If you don't know them, and you're a new worker, you’ll go with whatever they tell you, because a lot of mental health clients can tell you whatever they like, and you know, with us knowing them, we say, “Yeah that doesn't really happen” and they go, “okay”.

Not knowing the Community well could also result in potentially dangerous outcomes for clients as she described with this example.

We had a client who had been in and out of hospital, and then he's had a new worker who doesn’t really know him. Soon, they were helping him get all his files back when he was a child - through DHS - why he was taken away. But there’s stuff in those files that he should never know about. People do have the right to know about their history in their files. But if he learns about this, it is going to send him over the edge. He doesn't need to know that sort of stuff.
So the new worker doesn't know him that well. They've gone ahead and ordered all these files for him. Now he's on the edge, he doesn't know what to do. I'm not a mental health worker, but if I had known this earlier, I would have stepped in and said, “Don't do it”. These are the reasons you don't do it ... without going into too much of his history or breaking confidentiality... So that's a damage that can be done by people not knowing him or knowing the Community.

While employing KMHLOs from the Community had its advantages, some participants indicated that care needed to be taken while choosing the right individual for that position. The ideal person would be an older person with a good reputation across all sections of the Community. A person who was drawn into conflicts between family groups would not be able to effectively carry out the role of a KMHLO. An Elder described this situation when he said:

People won't go to a certain place because of who's in that position. It might be some family history or tribal history or something like that, that's gone on for years and years and they purposely won't go and see that particular person. – KMc2

Another potential barrier to engaging with the KMHLO emerged when the later was closely related to the client.

Another one might be that they're related in some way. – KMc2

When asked whether male clients would feel comfortable with a female KMHLO, this Elder said that in a hospital setting, it was not so much of a problem as long as the KMHLO confined discussions to family and other related issues rather than talking about the core mental health problems.

The males don't feel like going to a female anyhow, but they will talk to me in the hospital setting. Even though I'm talking to them, it's about family issues and other stuff around their problems, so I'm not right in their face wanting to talk about their mental health issues. So, it's a bit different. – KHLO
Expanding the role of the KMHLO was therefore indicated as a potentially useful method of improving utilisation of mental health services.

**Summary**

Improving help seeking and utilisation of services by Koori men requires interventions both within the Community and within the services. The first step in the process is to improve awareness regarding mental illness in the Community. Men clearly outlined the type of awareness programmes that could help, the method of organising such programmes and the key messages that were to be used. Apart from conducting awareness programmes, it is also important to empower men to disclose their problems. This is important since even when they were aware that something was wrong, there were several factors that dissuaded men from disclosing their problems and seeking help.

Services on the other hand need to work on building their reputation and trust with Koori men and the Koori community at large. This could be done by more interaction with men and the Community in non-professional settings aimed at building relationships. Services could also be more flexible in their approach to care of Koori clients such as conducting assessments in less threatening environments and giving the family an important role in care of clients. Finally, the KMHLO was considered to play a potentially significant role in boosting confidence and rebuilding trust of clients in the service. Characteristics of this individual included being approachable, being able to interact more closely with the Community such as by visiting people in their homes and knowing the community and understanding its dynamics. Therefore it was necessary for the KMHLOs to be from the Community that they served. Expanding the role of the KMHLO such as having a team of them could improve coverage of the entire region as well as overcome problems with family feuds and being related to clients.
Chapter 7

Discussion

The central research question of this study was to determine the key factors that influenced the utilisation of mental health services by Indigenous men. These factors included those relating to men and their Community as well as those relating to the mental health services. The thirteen themes that emerged from the data have offered insights into issues around men’s help seeking, the mismatch between mental health service delivery and Koori men’s needs and finally possible future directions to improve both Indigenous men’s help seeking and utilisation of services. The findings offer a critical perspective of help seeking by Indigenous men as well as barriers to service provision from the two central groups of stakeholders; the men themselves and the service staff. Importantly, the third finding offers a way forward. The dual perspectives of Indigenous men and service providers about current issues with service delivery and ways to improve it have not been previously offered. These perspectives are discussed in relation to the literature below.

Help seeking by Indigenous men

Recognising the problem

This study found that there is a lack of awareness about mental illness among Koori men in Gippsland. Mental disorders were less frequently recognised as problems of a psychological nature. People mistook a mental illness for a physical health problem such as diabetes or hypertension. Although studies in the general population have shown that a major reason for non utilisation of services is the difficulty in recognising the problem (due to a lack of awareness), similar studies have not been previously conducted among Aboriginal people except for one report.
from the Northern Territory which alludes to a lack of awareness of mental illness (Eley, et al., 2007). Moreover, what this study adds is a description of the factors that are associated with both the low levels of mental health awareness and the different understandings of mental illness among Koori men.

The results identified four factors that were associated with difficulties in recognition of mental health problems by Indigenous men. First, there is discordance between the mainstream use of labels and the Community’s use of traditional terms. Second, mental health problems are not discussed within the Aboriginal Community. Third, many Aboriginal men with mental health problems tend to live alone and are hence not exposed to information about mental health problems and finally, in families where more than one individual has a mental illness, recognition of a problem is unlikely.

The disparity in the concepts of mental illness between the mainstream and Indigenous men came to light in this study. Whilst the mainstream used labels for the various mental disorders, many Aboriginal people used traditional terms for those who behaved differently. While mainstream services and awareness programmes focussed on illness descriptions, Koori men focussed on abnormal behaviour. Koori men in this study alluded to two distinct types of problems that could well fall under the Western concept of a mental illness. The first type of problem related to worries and low mood (Don’t be a wuss, get over it, everybody has that sort of drama) and the second pertained to disturbed or violent behaviour (When they walk out of their house, slam the door, using abusive language...). The first type of problem was considered to be only a sign of weakness that men were expected to overcome by themselves. The second type of problem - that of violent or disturbed behaviour was considered by some as being a mental illness.
On the other hand, traditional terms such as *Dembin* referred to those whose behaviour was not commonly seen as normal. However, such individuals were considered as being more eccentric than mentally ill. This finding has been supported by Swan and Raphael, (1995) who state that traditional terms used to describe abnormal behaviour among Aboriginal people did not necessarily imply the presence of a mental illness. These differences in understanding of mental health problems could perhaps also explain why initiatives such as that of Beyond Blue, that have improved recognition of depression and schizophrenia in the general population (Highet, Luscombe, Davenport, Burns, & Hickie, 2005) have not had a similar impact on Aboriginal communities.

Mental health problems are not discussed within the Koori community perhaps due to a combination of poor awareness and the stigma attached to it. This is a significant finding particularly since Community discussions are a common method of information sharing within Indigenous communities where health information is shared during informal family gatherings and is quickly spread by word of mouth through the Community (Owen, 2006). Additionally, in health awareness programmes, Indigenous people prefer to use the local language or ‘Aboriginal English’ in ‘story telling’, ‘local artwork’ and ‘local music’ to spread health messages (Nagel, Thompson, Robinson, Condon, & Trauer, 2009). Respondents from this study also stated that if messages that appeared in the mainstream media did not clearly include Indigenous people, the latter might feel that those messages were not meant for them. Indeed, health messages developed for the mainstream Australian population are not suitable for Indigenous Australians (Owen, 2006). The reluctance to access services and accept health messages from a mainstream culture that is different from one’s own has also been reported elsewhere (Rogler & Cortes, 1993).
Another interesting finding in this study was that several Aboriginal men in Gippsland lived alone and were consequently not exposed to mental health information. A similar phenomenon has been reported in a western study which suggests that men living alone do not seek help as readily as others (Moller-Leimkuhler, 2002). In Australia, 14% of Indigenous households are lone person households and this figure is expected to rise over the coming years with more and more men of all ages being likely to live alone (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). This is thought to be due to the effects of separation and/or divorce and a general tendency for young men to live alone (Trewin, 2004).

Respondents also indicated that in families where more than one individual had a mental illness, recognition of a problem was unlikely. Reasons for this are not clear. However, one explanation could be that if certain signs and symptoms were present in more than one family member, it was perceived by family members to be a normal reaction to life stressors. This is particularly so for young people who may be struggling with their distress but may not have support from their Elders who have their own load of grief to bear (Dudgeon, et al., 2000). This finding also reflects a high prevalence of mental disorders in the Koori community.

From these findings, it appears that strategies that are developed to improve recognition of mental health problems among Koori men must address the following issues: the use of traditional terms relating to a mental health problem, ways to promote discussion of mental health problems in the Community, ways to target men who live alone and families where more than one individual has a mental illness. Mental health literacy programmes such as Aboriginal Mental Health First Aid (AMHFA) (Hart, Jorm, Kanowski, Kelly, & Langlands, 2009) which focus on
improving awareness of mental illness and suicide prevention among Indigenous Communities are a step in the right direction. AMHFA training programmes using the standard classroom method have been conducted in the region where this study was carried out. However, the impact of these programmes is not known. Moreover, it has been acknowledged that the method of delivery of this programme needs to be further tailored to meet the needs of the Community (Kanowski, Jorm, & Hart, 2009).

Deciding that help is necessary
Few Indigenous men are able to take the decision that help is necessary for a mental health problem. In the mainstream population, this decision is facilitated by higher educational status, support from family and friends (Angermeyer, et al., 1999; Rickwood & Braithwaite, 1994; Thompson, et al., 2004) and a high degree of psychological distress (Deane & Chamberlain, 1994; Thompson, et al., 2004; Yokopenic, et al., 1983). Reports from the Australian general population indicate that the majority of men would not have sought help if not for support from family and friends including intimate partners and GPs (Cusack, et al., 2004).

It is well known that education levels for Indigenous people are lower than that for the mainstream population. It is no different for those in Gippsland (Australian Bureau of Statistics, 2006a). Peer support was not apparent either. Men in this study indicated that even when they were able to overcome their inhibitions and talk about their problems, they were advised to ‘toughen up’. Thus there was peer pressure not to talk about problems resulting in men evading the issue when it was brought up. When levels of psychological distress were high, men used other coping strategies to deal with it. This is discussed in more detail later in the chapter.
Deciding to seek help for a mental health problem

Misconceptions that relate to being ‘tough’ appear to be common among Koori men. These misconceptions hinder the decision that help is necessary for a mental health problem. The decision to seek help was influenced by different factors depending on the type of problem. Seeking help for low mood and other depressive symptoms was not encouraged by peers and so men were persuaded not to disclose or talk about them. This was due to the perception that Koori men needed to be tough in order to fulfil their role as provider to the family. This role of provider had also to be safeguarded in society.

Men were reluctant to seek help for disturbed or violent behaviour as well. Whilst this type of behaviour was frowned upon by society, it was not enough to ostracise those who behaved this way. However, if men did seek help for these problems from mainstream mental health services, they ran the risk of being labelled ‘mental’. It was perceived that the old practice of ostracising those who were labelled ‘mental’ or abnormal from the Community could happen even today. Thus stigma associated with being abnormal or being ‘mental’ was thus a major barrier to seeking help for such problems. Another reason for why men did not want to seek help for a mental health problem was that they were fearful of being separated from their families by government welfare agencies (e.g. having their children taken away from them). Finally, Indigenous men did not appreciate being told that they had a mental illness by mainstream figures of authority whom they distrusted and disliked. Owing to the above reasons, men did not want to seek help for their mental health problems.

Men in this study also indicated that they were not comfortable with the term ‘mental illness’ which implied that ‘there was a problem in the head’. They did not want to be labelled ‘mental’ since the term caused fear among Aboriginal people and those diagnosed with it were considered ‘nuts’. Interestingly, other reports support this
finding (Lette, Wright, and Collard, 2000; Dunlop, 1988). One of these reports also indicates that Aboriginal people tend to stay clear of and tease and belittle those diagnosed with a mental illness (Lette et al., 2000). The use of the term ‘mental’ hence does not seem to help Aboriginal men but serves as a barrier to their help seeking for a mental health problem. Furthermore, ubiquitous conditions such as depression are not distinguished from rarer disorders such as schizophrenia by the term ‘mental illness’. Consequently, some authors have questioned the very use of the term (Patel, 1996).

When Koori men did talk about their stress to their peers (perhaps in order to seek support and advice on what to do about it) the latter tended to discourage them stating that Koori men had to be ‘strong’. Being strong was therefore considered to be culturally acceptable or ‘normative’ and men did not want to be perceived otherwise (Cialdini & Trost, 1999; Courtenay, 2000). The need to be strong is an attitudinal factor relating to masculinity and has been widely reported in the general population as well (Courtenay, 2000; Mansfield, et al., 2005; Reupert & Maybery, 2009). There is also possibly a strong felt need among Indigenous men to display toughness in an environment where they have to constantly battle with issues such as poverty, unemployment and racism (White, 2002).

The finding that Koori men don’t talk about their problems is interesting in that it adds to the debate on Aboriginal social intercourse. Lette et al. (2000) state that culture encourages Aboriginal young people to be strong and not burden others with their emotional problems although people in their cohort did support the view that young people needed to talk about their problems in order to stay strong. Reser (1991) on the other hand argues that for Aboriginal people, communication of how one feels is of utmost importance. Similarly, Roe, a Karajarri/Yawru man from Broome states that in the Karajarri culture of Western Kimberley, men are instructed
to openly communicate their grievances in order to keep their *Ngartlu* (or inner spirit) clear (Roe, 2001). He further argues that suppressing emotions is ‘white man’s way’ and that Indigenous men have adopted this pattern of behaviour to the detriment of their health. It has also been suggested that the cues employed to communicate feelings are less verbal but more using body language and other non-verbal gestures (Reser, 1991). Participants in this study did not speak about non-verbal cues. This could have been either due to an absence of such mechanisms or that they did not feel it appropriate to share that information with the researcher.

Although various suggestions have been made on ways of communication of feelings among Indigenous people in the literature, the problem of Indigenous men not talking about their emotions and feelings has emerged as a concern among men in this study and is a key barrier to help seeking. This has potentially grave consequences. A report from Western Australia has cited lack of emotional outlets and lack of communication within Aboriginal families as two important factors that contribute to self-harming behaviour in young people (Western Australia Office of Aboriginal Health, 1999).

**Deciding the type of help needed**

As discussed previously, men did not seek help for their mental health problems but rather employed other coping strategies such as the use of alcohol and other substances. Men believed that they could overcome their mental health problems with alcohol. The use of alcohol by Aboriginal people as a coping strategy is well known (Brady, 1992; Reser, 1991) and its damaging effects on Indigenous society has also been widely reported (Australian Bureau of Statistics, 2010; Brady, 1992; Calabria, Doran, Vos, Shakeshaft, & Hall, 2010; Gray, Saggers, Wilkes, Allsop, & Ober, 2010). Men in this study also bemoaned the fact that younger men are learning to drink excessively from their Elders thereby perpetuating the trend.
A coincidental finding however was that men also attributed their alcoholism to their loss of culture, language and position in society. A key feature of this loss was that of their role to the women in the Community. This has also been reported in previous literature (NACCHO, 2010; Sergeant, 2009; Swan & Raphael, 1995). Men indicated that the women were more educated, had better jobs and earned money for the family. Traditional roles of Aboriginal men such as that of ‘leader, protector, provider and teacher’ (Hammond, 2010, p.24.) appear to have been lost and men are grieving over this loss. Men have hence lost their self-esteem and role as head of the family (Sergeant, 2009). The slow and systematic destruction of the role of Indigenous men is thought to have its origins during the time of colonisation (Adams, 1998). In his historical account of early Aboriginal Communities in Gippsland, Attwood (1989) states that missionaries endeavoured to create a ‘community of nuclear families’ where the husband had authority over the wife. In doing so, they maintained their power over the men. In the process, women perceived men’s authority as artificial and therefore needed to struggle against both the men and the missionaries. Attwood (1989) says this of women of the time:

[They] attained a firmer sense of self and considerable strength of character, and at the same time came to question whether men could play the roles prescribed for them by the missionary patriarchs. (p. 52)

If Aboriginal men’s wellbeing is to improve, men need to be empowered to regain their dignity and respect of pre-colonial times (Swan & Raphael, 1995). Helping men get back their self-esteem and status in society could be a long process. One possible way to promote this is the ‘Men Shed’ program (Sergeant, 2009). Regaining cultural vibrancy and spirituality has also been identified as imperative to community healing. This has been succinctly illustrated in a First Nation research report of Aboriginal people in Canada which states,
When communities have been forcibly separated from their own spiritual roots for a long enough time, a lack of vision and coherence at the core of community life tends to make it difficult for the people to ‘see’ any pattern of life for themselves other than the one in which they are currently enmeshed. On the other hand, it has been clearly demonstrated that rekindling spiritual and cultural awareness and practices can greatly strengthen the coherence and vitality of a community healing process. (Junior, Bopp, Bopp, & Norris, 2002, p.57)

Research carried out among the desert men of Central Australia also indicate the need for the renewal of cultural traditions such as Kanyirninpa or ‘Holding’ in order to maintain good health (McCoy, 2006). McCoy reports that young men from the region yearn to be ‘held’ (or be taken care of) by older men and the absence of someone to hold them could lead them to substance abuse and other unhealthy behaviour. In addition to regaining spirituality and traditions, self-help measures which can be utilised as early intervention strategies could also be offered to Indigenous men. These include regular exercise (for depression and generalised anxiety), use of St. John’s wort (for depression), and relaxation training (for depression and a range of anxiety disorders) (Jorm & Griffiths, 2006).

**Reluctance to contact services for mental health problems**

Koori men do not feel comfortable contacting mental health services. This is not surprising considering contacting the services leads to individuals being labelled and stigmatised by their Community. Aboriginal individuals are perceived to be abnormal by their Communities only when they are labelled as being mentally unwell by the services (Swan & Raphael, 1995). Accordingly, when individuals are socially labelled as ‘mentally ill’, their behaviour is reinterpreted by their culture as reflecting ‘mental illness’ (Meile & Whitt, 1981). This resulted in shame which means something stupid or embarrassing’ or ‘something wrong’ has occurred (Vickery, Faulkhead, Adams, & Clarke, 2004). Koori men therefore believed that contacting
psychiatric services was a ‘shame job’. Within the construct of this phenomenon, lie the two important elements of ‘labelling’ and ‘stigma’.

Men in the study clearly mentioned that they did not want to be labelled as ‘mental’ or as one who had visited the psychiatric services. It is clear that these services had a poor reputation among Indigenous people. This poor reputation is due to both collective negative experiences and the stigma of being labelled ‘mental’ (Lette et al., 2000). Studies from Europe suggest that labelling is a cultural issue. The portrayal of violent crimes perpetrated by individuals with psychosis in Germany resulted in strongly negative public attitudes towards those with similar disorders (Angermeyer & Matschinger, 1996). Whereas, in countries such as Russia and Mongolia where such crimes were hardly reported by the mainstream news media, the public did not attach much stigma to mentally unwell persons (Angermeyer, Buyantugs, Kenzine, & Matshinger, 2004). In Australia violent crimes carried out by individuals who are reported to be ‘mentally unwell’ are commonly featured in commercial news channels and these news items are easily recollected by people (Morgan & Jorm, 2009). News items and other television programs that showcase mentally ill persons as criminals have perhaps partly informed the current understanding of and attitudes towards these disorders among Koori men.

Furthermore, there is some debate on the effectiveness of accurate labelling as an enabler of help seeking and service utilisation. While some argue that labelling causes stigma and discrimination (Angermeyer & Matschinger, 2005), others argue that the use of psychiatric labels is beneficial for help seeking (Wright, Jorm, Harris, & McGorry, 2007). It appears however, that in communities where public knowledge about mental illness is good, labelling enables people to seek appropriate treatment. Whereas labelling can be counter-productive in areas where mental health literacy is poor. Currently, there seems to be a disparity between mental health literacy levels
in cities and in rural and remote areas. Communities where mass education campaigns have been successful (such as cities) tend to have better recognition of mental health problems and thereby better utilisation of services (Reavley, et al., 2010). In rural and remote communities, where disorder specific terms are poorly understood, mental health problems are explained as being due to domestic and financial situations (Fuller, et al., 2000).

Stigma also played an important role in men choosing not to contact mainstream mental health services. However, stigmas are of different types. They can be readily apparent (such as gender and ethnic group) or hidden (such as religion and sexual orientation) (Goffman, 1963). In the general population, mental illness is usually hidden but can become apparent with social cues such as disruptive behaviour, violence or poor social skills (Schumacher, Corrigan, & Dejong, 2003). However, the results of this study indicate that much of the stigma was attached to contacting mental health services. This is an interesting phenomenon where in owing to a lack of awareness of what constitutes mental health problems and a generally high level of tolerance for abnormal behaviour in the Koori Community, those who were not yet diagnosed with a problem by the service were able to move about without attracting much ‘shame’. Severe psychological distress was overcome with alcohol (albeit temporarily). Being intoxicated appeared to be more acceptable in society than being labelled ‘mental’. Men seemed to be aware that contacting mental health services would label them as being abnormal and thereby threaten their (already tentative) standing in society. Staying away from those services was therefore the preferred option for those with a mental illness. Thus in order to reduce the stigma of mental illness among Indigenous men, one of the pre-requisites would be to destigmatisate mental health services and mental health care.
Reluctance to be treated by staff of the opposite sex was not considered a major issue by men in this study although they preferred to be seen by a male. However, this seemed to be a problem for the Koori Mental Health Liaison Officer who refused to participate in the study due to it being related to men’s health. This was surprising since the KMHLO who was a female was responsible for all Indigenous clients (both male and female) of the regional mental health service. This highlights the need for gender specific staff in the services. More on this will be discussed later.

The other findings that relate to contacting mental health services such as not being comfortable to share one’s inner feelings with the mental health clinician and the lack of family support have also been reported in studies from Western populations (Komiya, et al., 2000; Vogel & Wester, 2003; Angermeyer, et al., 1999; Rickwood & Braithwaite, 1994). In fact, in a major report on help seeking for a mental health problem by the NHMRC, 66 percent of men indicated that their decision to seek help was influenced by other people (Deane, Wilson, Ciarrochi, & Rickwood, 2002). The finding that stigma, lack of trust and racism influence help seeking from mental health services are similar to those from other reports of Indigenous help seeking (Briscoe, 2000; Henry, et al., 2004; Wenitong, 2002).

**Mainstream services for Koori clients: The mismatch**

This relates to the incongruence between the services and the needs of Koori men and identifies three main areas of divergence. They include barriers to gaining entry into mental health services, issues with engagement with Koori men and staffing problems.

**Gaining entry into the service**

Koori men have difficulty gaining entry into mental health services. This is due to an extended waiting time as well as a stringent triage system. It appeared that Koori
men had difficulty waiting for prolonged periods of time to obtain treatment. This finding has been supported by other reports as well (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008; Wenitong, 2002). One possible explanation for this is that Indigenous men usually seek help from services when they are in a crisis (Briscoe, 2000) and having to wait could increase their distress. Not much is known in the general population about waiting time as a barrier to seeking help for a mental illness.

However, there is evidence to suggest that a long waiting period is a barrier to help seeking for substance use (Appel, Ellison, Jansky, & Oldak, 2004). For substance users, being on a waiting list can raise doubts about the capacity and perhaps the willingness of services to provide the support they need. Substance users tend to have unstable lives and be undecided about seeking treatment. As a result, if timely treatment is not provided, they tend to believe that the services are not prepared to help them (Brown, Hickey, Chung, Craig, & Jaffe, 1989). Furthermore, the long wait might mean that other events could arise that further interrupt treatment seeking (Redko, Rapp, & Carlson, 2006). Some authors are of the view that the first 24 hours of client contact is a critical period in initiating services (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995). This is perhaps due to clients usually contacting services in a crisis or have temporarily overcome other hurdles to seek treatment (Redko, et al., 2006). Given the high prevalence of co-morbidity (dual diagnosis) among Indigenous people, the known literature on substance users might be able to explain some of the difficulty faced by Indigenous men with a mental illness. Co-morbidity itself has been considered an independent deterrent to obtaining entry into services. In such situations, having to wait for extended periods of time could be distressing.
Apart from the waiting time, the triage system that operates in mental health services serves to filter out those who are not in urgent need of treatment. This has resulted in Koori men being turned away from admission to services. The widely bemoaned lack of adequate resources in rural mental health services perhaps has a role to play in causing triage criteria for admission to be made very stringent.

**Barriers to engaging Koori men**

In this study, both Indigenous men and service staff emphasised that the main deterrent to engagement was a deep sense of distrust of both services and service staff. This they indicated lay at the centre of most of the problems in engagement with Koori men. This lack of trust seems to have been born out of generations of negative experiences with mainstream services. Consequently it took considerable time for services to build trust with clients before any meaningful engagement could take place. Although some staff were willing to give time to building a therapeutic relationship, this did not often lead to expected outcomes. The differential use of language and non-verbal communication were also indicated as barriers to engagement with Koori men. This has been supported by other authors as well (Eley, et al., 2006; Eley, et al., 2007; Shahid, Finn, & Thompson, 2009).

As discussed earlier, Indigenous men prefer to have their problems sorted out immediately and mostly seek help to tide over the crisis that was at hand. Once the crisis had passed, men seemed to have lost interest in the service. Using Maslow's hierarchy of needs, one could argue that for individuals from low socio-economic groups, health might be relegated to a low priority concern as they have to spend considerable time trying to fulfil more basic needs (Hagerty, 1999). This possibility was also suggested by service staff who indicated that Koori men often did not keep their appointments due to multiple domestic problems that they had to deal with.
This vicious cycle therefore did not help the process of building trust between staff and Koori men.

A curious finding of this study was that men were able to hide the severity of their symptoms from clinicians thereby giving the impression that they were not unwell. Similar behaviour has been observed among another cohort of Aboriginal people with psychiatric disorders where a majority of those studied did not show abnormal psychopathology but instead showed remarkable coping skills and lived 'well-integrated' lives (Biernoff, 1982, p.152). However in the present study, it was not clear why men masked their symptoms. One reason why Aboriginal people may not disclose their symptoms is that doing so causes them significant cultural distress (Westerman, 2010). Whatever the reason, concealing mental symptoms appears to have potentially grave consequences for Koori men.

A lack of cultural competency in service delivery was another factor that impeded meaningful engagement. Westerman (2010), an Aboriginal psychologist, suggests that a way to overcome direct eye contact with Aboriginal clients during consultation is to sit side by side with the client looking down and only to look up at the client occasionally. She also advises that the client could be made comfortable with the involvement of a cultural consultant who could be appointed by the client himself. Furthermore, the finding that men were not able to adequately engage while they were inside the mental health service is supported by Hunter (1988) who states that Aboriginal people could appear more distressed than expected if they were assessed in environments that were alien to them.

The need to give the family equal importance in the care of clients was another important finding in this study and is supported by findings from other research (Eley & Hunter, 2006). This study showed that it was beneficial to involve the family in
treatment of Aboriginal clients. Involving the family was useful for obtaining key information that was not forthcoming from the client himself. Drew (2002) has also highlighted the importance of involving the family for triangulation of information. Mental health staff noted that knowing other members of the client’s family was also useful to locate clients when they were not present in their house. Another reason for getting acquainted with families of Aboriginal clients has been suggested by Westerman (2010) who states that if the clinician has knowledge of relations or ancestors, Aboriginal people are able to establish a connection with that clinician and that in turn can facilitate engagement.

Confidentiality was yet another factor that arose rather surprisingly from the study. Although staff were well aware of the importance of this aspect of patient care, they seemed to have problems with it. It appeared that in an atmosphere of distrust, some staff attempted to gain some credibility with their Koori clients by (‘name dropping’) indicating that they knew other members of the Community. However, this seemed to backfire as not maintaining confidentiality. A possible reason for this perhaps relates back to the poor reputation that mental health services and its staff have among Koori men and the Community at large. As a result even knowing someone in the service seemed to indicate that the individual had contacted mental health services and this could open up questions in the Community which in turn could lead to shame.

**Staffing problems**

Unplanned changes in staff responsible for a client’s care are unpleasant for all clients of mental health services but are particularly so for Koori men. This is perhaps due to the time taken for Koori men to build trust with clinicians and the difficulties in engagement that have to be overcome. Koori men therefore felt
frustrated when all the time and effort invested in developing a therapeutic relationship with one individual was suddenly lost owing to a change in staff.

The lack of Indigenous staff in services has been widely described as a barrier to utilisation of services and their involvement has resulted in improved utilisation (McKendrick, et al., 1990a; Nagel & Thompson, 2006; Norris, et al., 2007; Stathis, et al., 2007). For instance, Aboriginal Mental Health Workers in the Northern Territory help GPs with background information of clients and mediation in crisis situations (Robinson & Harris, 2005). Their input into client care has been praised by other non-Indigenous staff.

“They are invaluable in that they are a source of insight into culture, can work out who’s related to who, know how to find people and know what’s happening within the family.” (Robinson & Harris, 2005, p.55)

However, there is no standard or accepted model of Indigenous staff involvement in mental health services due to issues such as recruitment and retention, and a debate as to whether their role is purely cultural liaison or clinical or both (Harris & Robinson, 2007). Furthermore, a key element of a successful AMHW program is the recruitment of appropriate individuals to take up those roles – those with integrity and good standing in the Community as well as those who have the confidence of others (Robinson & Harris, 2005). Sadly, even when Indigenous mental health workers received formal and prolonged training, they are still considered as ‘seasonal workers' by the mainstream system (Brideson, 2003).

In Victoria, Koori representation in mental health services is mostly in the form of the KMHLO whose responsibilities are mostly restricted to cultural liaison work. In New South Wales, Aboriginal mental health workers spend much of their time building trust in services as this worker states:
'I have had to work with great persistence to build up a sense of trust in Aboriginal people that the health system is a safe place to go with their problems. This has taken me a long time.' (Latimore, 2007)

Obtaining Indigenous staff for specific Indigenous positions in Aboriginal Organisations itself can be a challenge in some Communities. For instance, currently, over a quarter (29%) of Indigenous positions in the Social and Emotional Wellbeing service are occupied by non-Indigenous staff. These workers are hired by Aboriginal Organisations for Aboriginal people (Australian Institute of Health and Welfare, 2010). Under these circumstances, selecting the appropriate individuals from the right mob could be difficult. Furthermore, a systemic lack of resources available for Indigenous mental health in rural areas adds to the 'bits and pieces' nature of mental health services that are available for Indigenous men in rural areas such as Gippsland.

**Addressing mental health needs of the Community**

In describing mental health needs of the community, it was found in this research that not only was there a need to improve awareness regarding mental health problems among Koori men but also a need for men to be empowered to disclose their problems to others and seek help.

**Improving mental health awareness in the Community**

Improving awareness regarding mental health and illness in the Community as a whole is the key to improving help seeking among Koori men with mental health problems. Koori participants outline clear guidelines on ways of improving mental health awareness in the Community. They describe the type of programmes that are necessary, the content of these programmes and ways in which to conduct them in order for them to be successful. They also highlight that the issue of mental health problems has to be first formally addressed by the leaders of the Community. This
had to be followed by workshops and awareness programmes on the topic thereby clearly pointing to an unmet need for mental health education in the Community.

Participants also highlight the need to de-stigmatise mental health education in the Community. This they indicate can be achieved by including mental health problems within a broader topic of men’s health. Highlighting the term mental would only push people away as they would feel that the program is only for those who were ‘nuts’. Blending mental health into the spectrum of men’s health is perhaps one way of destigmatising the programme. Another key approach to destigmatising mental health awareness programmes for Indigenous men is to embed the messages within their cultural concepts. This enables men to better relate to messages and adopt them. The importance of tailoring health messages for different groups and using appropriate media for conveying these messages has been reported by others as well (Noar, 2006). School based interventions are not uncommon in Australia (Spence, et al., 2005; Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000) and are perceived to be useful due to both addressing a captive population as well as fulfilling the need for early intervention.

Another unique finding in this study was that unlike general population based awareness programmes where telephone numbers and websites are published as contact details, this study showed that Koori men needed to know the individuals whom they could contact for services. This highlights the importance of personalising services for Indigenous men rather than relying on the current system.

The findings therefore indicate that there is an unmet need for mental health awareness among Koori men in Gippsland that awareness campaigns used for the mainstream population will not necessarily work for Koori men and that awareness
campaigns tailored specifically for Koori men need to be organised with ample participation of the Community and Elders.

**Empowering men**

Another key issue that emanates from this research concerns empowerment. Ways of empowering men to talk about their mental health problems appears to be a key to improving their mental health. This is supported by other Aboriginal authors such as (Briscoe, 2000) who state that empowerment is central to improving the health and wellbeing of Indigenous men. Koori participants in this research indicate that men could be empowered if they are encouraged to join men’s groups where they could discuss their problems confidentially.

It has been shown that being part of a men’s group can empower men in that it enables them to attain more awareness, seek help for their problems and be more open and communicative about their problems (Tsey, et al., 2004). The Yarrabah men’s group is an example of a successful Indigenous men’s group which has been running for more than a decade (Tsey, Patterson, Whiteside, Baird, & Baird, 2002). It started as a support group to improve men’s self esteem (through weekly education sessions, counselling and men’s health clinics) and social skills and bonding (through hunting, fishing and camping) (Tsey, et al., 2002).

Indigenous men’s groups have been established in many Communities in Australia with a common aim to empower men, support them in being a role model for younger men and address factors that contribute to social dissatisfaction and poor health and wellbeing in their Communities (Reilly, 2006 in McCalman, et al., 2006). Men’s groups also emphasise the need to have a culturally safe place for reflection, healing and re-establishment of men’s roles in society (McCalman, et al., 2006).
Furthermore, men’s groups are also a way of initiating sports and fitness programmes (McCoy, 2006).

There are also challenges that face men’s groups. For instance, they usually have a limited resource base with little or no funding. Leaders of such groups also tend to have limited education and training making it difficult to achieve the best outcomes (McCalman, et al., 2006). Another potential challenge facing the development of these groups is the divide between those in the Community who have jobs and those who do not making it difficult for groups to become close knit (Tsey, et al., 2002). Difficulties in maintaining attendance and participation has been identified as yet another long term challenge that faces men’s groups (McCalman, et al., 2010).

Making services more acceptable

As mentioned earlier in this thesis improving utilisation of mental health services required interventions both at the individual level as well as at the service level. While the previous sections have discussed what could be done at the individual level, the following focuses on what could be done at the service level to improve their utilisation by Indigenous men. This study identified four elements of a culturally acceptable service. They are: building trust and confidence in services, developing relationships with the Community, making services flexible and strengthening the role of the KMHLO.

Building trust and confidence in services

A key finding of this study with regard to making services more acceptable, related to building trust and confidence in them. While studies in the mainstream population have cited the lack of trust in caregivers as a barrier to contacting them, this study adds to the literature by also identifying possible ways of building trust and confidence in mental health professionals and services.
One way of building men’s confidence in services is by convincing Elders about the usefulness of these services. Recommendations from local Elders are an important element in building confidence. Unlike in the mainstream population where there is an assumption that people generally take decisions by themselves, among Indigenous communities, the Elders continue to exert considerable influence.

Another possible way of building confidence in services is for groups of men to visit the services as a goodwill gesture – as a way of getting them acquainted with what the service was about. This could be done as part of an educational tour of the service facility. The presence of Indigenous artwork and posters in services is also useful in building confidence (Teasdale, et al., 2008).

**Developing relationships with the Community**

Service staff need to be acquainted with Aboriginal men, their families and the Community and develop relationships with them. This has been emphasised by others as well (Haswell-Elkins, et al., 2009; Toomey, 2007). This is necessary in order to enable men to familiarise themselves with professional staff and those who represent mental health services. It also serves to breakdown any inaccurate preconceptions or myths relating to services and professional staff that men might have. This can be possible if service staff visit the Community on a regular basis either on a courtesy call or to participate in Community events. This expansion of the role of staff is also being suggested elsewhere. For instance, (Slade, 2010) argues that mental health professionals of the 21st century will need to routinely focus on ‘social inclusion’ and on challenging ‘stigma and discrimination’.

**Making services flexible**

An interesting finding from this study was that staff of the mental health services highlighted the need to modify service delivery to suit the needs of Indigenous men.
It included having a more mobile service where clients could be assessed and followed-up at locations other than the office as well as providing a bigger role for the family in client care. This they indicated could be achieved only by adopting a paradigm shift in approach to services for Indigenous people. Currently, this is achieved by breaking existing rules of engagement. In order to provide a more flexible service for Indigenous men, mental health staff noted that the current dearth of staff and other resources in mental health services had to be addressed first.

**Strengthening the KMHLO**

There is indeed an important role for the KMHLO in providing mental health services for Koori men. Firstly, the KMHLO can help to reduce the fear and unease that men encounter when visiting a psychiatric service. Secondly, Koori men prefer to have someone from their mob who can act as a mediator between the services and themselves – someone whom they can feel comfortable with. When a service can make its non-western clients feel comfortable, then it can consider itself culturally sensitive. Furthermore, a culturally sensitive service will be able to identify labels used by their patients for distress states (Littlewood, 1990) and also improve recognition of such distress states (Patel, 1996). The meaningful involvement of the KMHLO can improve cultural sensitivity of the service. They can help to clarify with clinicians differences in the terms used by men to describe their distress states in clients which clinicians may not recognise. In addition, the KMHLO is also responsible for supporting other mental health staff in providing a welcoming environment for Indigenous men in the service.

However, in order for the KMHLO to be able to fulfil those roles, there are certain pre-requisites. The KMHLOs must be from the Community so that they know the people and families and understand the Community dynamics. It is also important for them to be active in the Community rather than confining themselves to the
office. Furthermore, given the large geographical area that is covered by the service and the widespread nature of the Communities, it is necessary to have a team of KMHLOs. This can also help to overcome issues arising from family conflicts and being related to clients. Koori men could then have a better opportunity to identify a KMHLO who they are comfortable working with.

**Learnings and limitations**

**Lessons learnt in engaging with the Koori community**

Several lessons were learnt during the process of engagement with the Koori community. For instance, although all precautions had been taken to ensure that the research was respectful, recruitment of participants in two Communities was less than ideal. This was primarily due to the lack of time, an issue raised by other authors as well (Couzos, Lea, Murray, & Culbong, 2005; Mayo, et al., 2009; Shahid, Bessarab, & Thompson, 2009). Providing an adequate time-frame for the research allows for a relationship to be built between the researcher and the Indigenous Community (Mayo, et al., 2009; Waples-Crowe & Pyett, 2005). One CA suggested that for a community-based PhD research project of this size and scope involving Indigenous Communities with little research experience, five years would be an adequate time frame. Another likely reason for recruitment difficulties was the stigma usually associated with mental health problems, which is intensified in Indigenous Communities where ‘shame’ exacerbates people’s reluctance to discuss such private matters with service providers, or other outsiders such as researchers.

CAs were an integral part of this study. Without their support and encouragement, this study would not have been possible. It is paramount that CAs are well received and respected in the Community. CAs need to have a greater understanding of the various issues that are present in the Community that may be otherwise hidden.
They need to be involved in the Community’s cultural activities and gatherings as well as in the various formal and informal Community groups such as men’s groups.

Another lesson learnt from this research was that it would have been useful to have more than one CA for each Community. In addition, the CAs in this project did not receive any reimbursements for their time and effort. Since CAs are otherwise busy people, advising student research presented an additional burden without financial or other reward (Shahid, Bessarab, et al., 2009). Community Elders in particular who accept the role of a CA bring with them a vast body of experience which could significantly enrich the research process. Perhaps, if they were considered part of the supervisory team and made eligible for remuneration just as their academic counterparts, the research would have demonstrated more Equality.

In order to be accepted by the Community, the researcher needs to first be accepted by the CAs and develop a relationship with them. That requires patience and flexibility, qualities that will go a long way in engaging with the Community as well. An attitude of ‘We’ve got to meet at this time at this place’ or ‘We’ve got to get X number of participants’ does not work. Repeated postponements of appointments must be accepted by researchers as family and Community gatherings as well as funerals are a priority for Koori people. Crespigny and colleagues have also noted that flexibility was a key factor in their success with developing partnerships for Indigenous research (Crespigny, Emden, Kowanko, & Murray, 2004). Since this was the first time research involving cultural advisors was carried out in the study region, they required time to determine that I was respectful and that the research was outcome-oriented before committing to engage with me and the research process. Once the process of recruitment had commenced, participants generally discussed their experience with the CA. CAs relied on participant feedback to reassure themselves that the research process not only did no harm but was also of benefit to
the Community. This was also an opportunity for the CAs to learn about the research process.

A useful way of getting to know the Community is by attending gatherings such as those that take place during NAIDOC week celebrations. That’s when Community members can put a face to the name. One needs to approach the research with respect, understanding and empathy for what Koori people have endured over the years. When engaging with Koori people one also learns the value of humour, which is an endearing characteristic of their culture and a mark of their resilience and survival. One cannot just say or assume that the researcher has these qualities. What is more important is how the researcher demonstrates this. The researcher cannot come across as too forward, pushy or disingenuous because Koori people will pick up on it straight away. It was noted that Koori people are a good judge of character and integrity in a person. As one of my CAs said, ‘they have had to do it all their lives to figure out where they stood with outsiders’. Respect is a very important value in the Koori Community and the researcher needs to demonstrate this at all times. Furthermore, when discussing sensitive issues such as mental health with men, a little smile or the ability to share a laugh with them can go a long way in developing mutual trust.

It was initially expected that Koori men would prefer focus groups (where ideas can be shared and opinions exchanged) to one-on-one interviews as the former have been found to be appropriate in many studies with Aboriginal communities (Holmes, Stewart, Garrow, Anderson, & Thorpe, 2002). Outcomes have also been found to be better if the focus groups were facilitated by a Koori researcher and the results were interpreted by him. However, in this study, although the option of a focus group was offered to cultural consultants and participants, they were all comfortable with a
one-on-one interview. This was perhaps due to both the sensitivity of the topic as well as the trust that was gained by being recommended by a well respected man in the Community (my CA).

**Lessons learnt in engaging with mental health professionals**

All focus group discussions with service providers took some time to become free flowing. I felt that participants were initially studying me and my attitude. I am dark skinned and from a non-Western background and perhaps they felt that I was there to find fault with them for the problems of Koori people. I realised that they were not very comfortable talking about their Indigenous clients. I also got the impression that they did not have many positive experiences to share although only a small number of them actually worked with Indigenous clients. Therefore, to put them at ease, I shared some of the difficulties that I had experienced in running a rural mental health service for culturally diverse groups in a cash strapped environment. This possibly enabled them to feel that I could understand the issues better.

As a result, not too long afterwards, participants perhaps realising that I maintained a neutral attitude and could potentially help improve their interactions with Koori clients, began to open up and discuss issues more freely. During the focus groups with mental health professionals, I observed that there were some individuals who were more enthusiastic than others about addressing the challenges to working with Indigenous people. This is perhaps owing to the fact that some members in the group had limited experience in directly working with Indigenous clients. However, there seemed to be a consensus in what was being said as indicated by a nodding of heads (Stevens, 1996; Willis, et al., 2009).

**Limitations of the study**

There are a number of limitations of this study. Firstly, Koori participants (men and carers) did not represent all Indigenous groups from Gippsland and were mostly
introduced by one CA. Being an outsider, building trust with the Community required more time and the opportunities to build this trust were few. This was therefore a new experience for all concerned and every step of the process took longer than expected.

The role of GPs as the first port of call for those with symptoms suggestive of mental health problems has not been discussed. The focus of this study was primarily on factors affecting utilisation of public mental health services. It is also notable that previous literature on help seeking for mental health problems by Indigenous people has not referred to the involvement of GPs. Moreover, since respondents in this study rarely mentioned GPs as a help-seeking option, it was not explored further. Although some Western studies suggest that the most common source of help for adults with mental health problems are general practitioners or the out-patient departments at hospitals (Gater, et al., 1991; Jorm, Wright, & Morgan, 2007), reports from more traditional societies indicate that mental health problems are resolved by social and psychological support from family and friends (Kermode, Bowen, Arole, Joag, & Jorm, 2009; Peluso & Blay, 2010).
Chapter 8

Recommendations & conclusions

This thesis establishes a comprehensive view of what is needed to improve Indigenous men’s help seeking from the perspectives of Indigenous men, their carers and mental health professionals. These multiple viewpoints offer a wide ranging picture of what is required to make changes to both the help seeking behaviour of Indigenous men in Gippsland as well as to mental health services. The findings from this study are important for a number of reasons. From the perspectives of Gippsland Indigenous men they offer hope and direction for improving their mental health and wellbeing. From the perspective of mental health services, the findings offer some starting points on how to make services more acceptable to their Indigenous clients.

The study then offers clear direction as to how both the Indigenous community and the service providers can adapt and change their focus and behaviour to improve help seeking and utilisation of mental health services by Indigenous men with mental health problems. It also recommends ways to improve engagement between men and the service staff. An important finding is that while previous studies have proposed four stages in help seeking for a mental illness, this study has highlighted that, for Indigenous men, disclosing one’s illness and having meaningful engagement with staff are key elements of successful help seeking.

Recommendations

The following summarises recommendations to improve help seeking by Indigenous men from the views and opinions of respondents as well as from the literature.
These recommendations have been categorised under the 5 steps of help seeking from chapter 2.

1. **Recognising the problem**
   Spread awareness of mental health problems and mental disorders among men and the Community in a culturally appropriate way (See Table 12 for details on how to spread awareness).

2. **Deciding that help is necessary**
   Promote and organise men’s groups; encourage single men to join groups.
   Empower men to talk about and share their problems in groups.
   Dispel myths and misconceptions regarding men with mental health problems (‘It is not a shame job to be crook’).
   Promote a positive image of men with mental health problems.
   Encourage discussion of mental health problems in the Community.

3. **Deciding to seek help**
   Educate men on the need to seek help for mental health problems.
   Include service providers (mental health professionals) in education.

4. **Deciding the type of help needed**
   Educate men on proven self management strategies (Such as exercise, St. John’s Wart, etc).
   Promote a positive image and usefulness of mental health services.
   Remove negative stereotypes of mental health services.
   Promote services among Elders and the Community.
   Staff from services can interact with men and the Community in informal settings such as NAIDOC celebrations and arrange for talks during these events.
5. Contacting the mental health service

Have more Indigenous staff or allow clients to be accompanied by an Indigenous person of their choice.

Have KMHLOs who can facilitate contact with services.

Have Indigenous posters and artwork in the service facilities.

Have a Koori specific place in the office (preferably with an outdoor area).

Promoting help seeking among Indigenous men with mental health problems is only part of the challenge in improving utilisation of services. Interventions to improve utilisation of mental health services need to focus both on the Community as well as on the services. Issues related to their engagement with mental health services are also to be addressed. Such a comprehensive approach potentially has a better chance of success than interventions targeted at either one of them. Furthermore, these interventions highlight the need for both the services and the Community to work together rather than for them to work in isolation towards a single goal. The following summarises interventions necessary to improve engagement between Koori men and mental health services.

1. Service staff could generate goodwill in the Community – participate in Community events.

2. Have cultural awareness sessions involving Aboriginal Elders and significant members of the Community.

3. Allow clients to be accompanied by an attendant of their choice or from the Community during consultation and assessment.

4. Enable flexibility of services (e.g. Conduct consultation and assessment in an environment that the client feels safe in).

5. Promote family involvement in care of Koori clients

6. Have a team of Koori Mental Health Liaison Officers who can provide more support in the Community.
Another key finding of this study focuses on Indigenous men’s views on the conduct of mental health awareness programmes. These findings have been collated in Table 12 to provide an outline of how a mental health programme could ideally be conducted for Koori men.

Table 12: Conducting mental health awareness programmes in Koori communities of Gippsland

<table>
<thead>
<tr>
<th>Type of programmes</th>
<th>Workshops</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>School programmes</td>
</tr>
<tr>
<td></td>
<td>Community Awareness Days</td>
</tr>
</tbody>
</table>

| How often?                  | Monthly or bimonthly                                                      |

| How to organise?            | Promote strong Community involvement from the planning stage.             |
|----------------------------|                                                                          |
|                             | Develop culturally appropriate delivery strategy with men and other      |
|                             | stakeholders.                                                            |
|                             | Invite Elders to participate.                                             |
|                             | Develop messages with the help of male volunteers.                       |
|                             | Target single men and families.                                           |
|                             | Aggressive promotion through Community channels.                         |
|                             | Invite Elders and men personally by house visits.                        |
|                             | Provide lunch / BBQ.                                                     |
|                             | Remove the term ‘mental’.                                                |

<table>
<thead>
<tr>
<th>Content of messages</th>
<th>Title: Men’s health (not mental health!)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Embed mental health and alcohol and drug messages using cultural framework.</td>
</tr>
<tr>
<td></td>
<td>Include what is and isn’t a mental health problem and the need to seek help and not hide one’s symptoms.</td>
</tr>
<tr>
<td></td>
<td>Promote a positive image of men.</td>
</tr>
<tr>
<td></td>
<td>Identify individuals who can help men with mental health problems.</td>
</tr>
<tr>
<td></td>
<td>Present what services are available.</td>
</tr>
<tr>
<td></td>
<td>Promote mental health services.</td>
</tr>
</tbody>
</table>

The emphasis is on removing stigmatising terms such as ‘mental’ from the programme by integrating mental health into the broader topic of ‘men’s health’,
extensive involvement of the Community and its Elders, providing a strong cultural context to messages and promotion of such programmes through Community channels. Messages also need to destigmatise mental health services by portraying it as a helpful agency rather than one that takes children away.

**Conclusions**

This study therefore reveals some key barriers as well as some possible facilitators to utilisation of mental health services by Indigenous men. The study highlights the difficulty in recognising mental illness as a key barrier to health services and reasons for the same. Reasons for the lack of recognition of mental health problems have not been reported previously and serve as a useful tool to develop interventions aimed at improving awareness and mental health problem recognition among Indigenous men. This study also identifies the difficulty in disclosing one’s illness as a key barrier to help seeking among men. This is the first time this barrier is being reported among Indigenous men. The key areas where there is a mismatch between mainstream service delivery and Koori men’s needs have also been highlighted.

Finally, this study also provides some future directions on ways of improving men’s help seeking as well as utilisation of mental health services by Indigenous men. Moreover, unlike previous reports which have highlighted the need to make mental health services more culturally sensitive, this research has found that improved utilisation of services can be achieved by building more trust and confidence in services which can in turn be made possible by more informal interaction between mental health providers and Community members.

The distinctive aspects of this research are multiple. First, it provides the first in-depth exploration of help seeking among Indigenous men with mental health
problems. Second, it sheds light on the various barriers to Indigenous men accessing mental health services. Third, it gives voice to Koori people to indicate how they expect mental health services to be culturally appropriate. Fourth, it provides the first report of dual perspectives of Koori men and carers as well as service providers in improving services. The best solutions for a difficult situation are usually those that include perspectives of all stakeholders. Finally, the research was carried out in a culturally appropriate way and in so doing; the researcher has not only been able to identify real problems but also taken a step forward in improving the reputation of research among Indigenous men in Gippsland. Future research will have to determine the feasibility and usefulness of interventions suggested here as well as explore how Aboriginal concepts of psychological problems could be incorporated into mental health services.
References


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Appendix 1: Support letters from cultural consultants and RDAC

From,
Mr. Hugh Pepper

To,
Dr. Anton N. Isaacs
PhD candidate
Monash University Department of Rural and Indigenous Health
PO box 973 Moe, VIC 3825

Dear Anton,

Thank you for your letter seeking support to carry out your research study titled, "Factors that facilitate and inhibit utilization of mental health services by Indigenous men in Gippsland: A Case study".

I will be pleased to offer support in the following ways:

Act as cultural consultant for your study – guide you with culturally appropriate methods of collecting information for your study
Introduce you to Aboriginal and Torres Strait Islander (ATSI) men aged 18 to 65 years who are consumers of mental health services in Gippsland and their carers and others who would be able to provide you with information for your study
Facilitate any focus group discussion with ATSI men on the said topic

Thanking you,
To: Dr. A. Isaacs  
PhD candidate - Monash University Department of Rural and Indigenous Health  
PO box 973 Moe, VIC 3825

Re: Letter of support for Research Study:

“Factors that facilitate and inhibit utilization of mental health services by Indigenous men in Gippsland: A Case study”

Dear Anton,

Thank you for your letter seeking support to carry out your research study, I would be pleased to offer my assistance for your study in acting as cultural consultant for your study. In this is will be able to facilitate and guide you in your interactions with the local Aboriginal and Torres Strait Islander people within the communities of Sale and surrounding areas.

I am pleased that you have approached myself and the CEO of Ramahyuck District Aboriginal Corporation Dr. Ali Khan, before undertaking your study. It is important that prior contact is made with community people before any activity relating to the study is undertaken.

I would like to meet with yourself and Hilton to arrange and begin the process of the preparation of your surveys and questionnaire. I would expect that this will take approximately 2-3 weeks as we will not be meeting with all interested people at the same time due to various demands on their time and my own limited availability.

I understand that Dooka (Hughie) Pepper from the Latrobe community and Larry Levi from Bairnsdale will also be involved in this study. This is also to be commended because though we are all ATSI people there can be varied viewpoints within communities and it is important to acknowledge those regional differences.

Please contact me via the above mediums if you have any questions or issues which require clarification.

Yours sincerely,

[Signature]

Phil Perry  
Human Resource Manager  
Ramahyuck District Aboriginal Corp.
From,
Mr. Larry Levi
Social and Emotional Wellbeing Officer
Gippsland and East Gippsland Aboriginal Cooperative
PO. Box 634 Bairnsdale 3875

To,
Dr. Anton N. Isaacs
PhD candidate
Monash University Department of Rural and Indigenous Health
PO box 973 Moe, VIC 3825

Dear Anton,

Thank you for your letter seeking support to carry out your research study titled, "Factors that facilitate and inhibit utilization of mental health services by Indigenous men in Gippsland: A Case study".

I will be pleased to offer support in the following ways:

1. Act as cultural consultant for your study – guide you with culturally appropriate methods of collecting information for your study
2. Introduce you to Aboriginal and Torres Strait Islander (ATSI) men aged 18 to 65 years who are consumers of mental health services in Gippsland and their carers and others who would be able to provide you with information for your study
3. Facilitate any focus group discussion with ATSI men on the said topic

Thanking you,

Yours sincerely,

Larry Levi
11/3/2006
28.3.2008

Dr Anton N Isaacs, MBBS, MD
PhD Candidate
Department of Rural & Indigenous Health
School Of Rural Health
P.O. Box 973
Moe Vic 3825

Dear Dr. Isaacs,

Re: Letter of support for undertaking research on mental health study.

Thank you for your letter seeking permission to carry out research titled, "Factors that effect the use of available mental health services by Aboriginal and Torres Strait Islander men in Gippsland" under the auspices of the Ramahyuck District Aboriginal Corporation.

On behalf of Ramahyuck, I am pleased to confirm the following support for your project:

1) Use the premises at Sale and Morwell offices for conducting interviews and Focus groups.
2) Interview medical officers and other staff working in the area of Social and Emotional Wellbeing, with prior arrangements with the program coordinator.

I understand that our support is subject to the following conditions:

1) Appropriate acknowledgement of Ramahyuck support is recorded in the final report.
2) That any reference made in the report as a result of the interviews with staff or any community member will not be published unless you have sought written consent from person concerned.
3) That you are covered by the university liability insurance at all time during your study at any premises of Ramahyuck.
I am pleased to accept your complimentary offer of training our Social and Emotional Wellbeing staff, during the course of your research.

Thanking you,

Yours sincerely,

Dr. Ali Khan BJ JP
Chief Executive Officer
Appendix 2: Ethics Approval letters

MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)
Research Office

Human Ethics Certificate of Approval

Date: 19 June 2008
Project Number: CF08/1409 - 2008000695
Project Title: Factors that facilitate and inhibit utilisation of mental health services by indigenous men in Gippsland: A case study
Chief Investigator: Prof Mark Oakley Browne
Approved: From: 19 June 2008 to 19 June 2013

Terms of approval
1. The Chief Investigator is responsible for ensuring that permission letters are obtained and a copy forwarded to SCERH before any data collection can occur at the specified organisation. Failure to provide permission letters to SCERH before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. Amendments to the approved project: Requires the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. Future correspondence: Please quote the project number and project title above in any further correspondence.
8. Annual reports: Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. Final report: A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. Monitoring: Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. Retention and storage of data: The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Ben Canny
Chair, SCERH

Cc: Mr Hilton Alexander David Grui; M. Priscilla Pyett; Mr Peter Waples-Crowe; Anton Isaacs
09 February 2009

Dr Anton N Isaacs
Department of Rural and Indigenous Health
Faculty of Medicine, Nursing and Health Sciences
Monash University
PO Box 973
MOE VIC 3825

Dear Dr Isaacs

LRH HREC Ref Number: 2008-15
Title: Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study

I am pleased to advise that Latrobe Regional Hospital Human Research Ethics Committee approval has been given to the above named project.

This approval is effective as at 09 February 2009 and enables your study to commence as outlined in your application.

In accordance with the NHMRC Guidelines, approval is subject to:

- HREC approval for any proposed modifications to the project;
- Notification in writing to the HREC Secretariat of the project commencement date and; completion of the Research Project Reporting Surveillance Procedures as outlined in the attached documentation.

Please quote LRH HREC Ref No: 2008-15 allocated to your study on all future correspondence.

Please do not hesitate to contact the HREC Secretariat by emailing: hrec@lrh.com.au or telephoning (03) 5173 8811.

Sincerely

Nicole Anderson
Executive Administration

Enc: Notification of Commencement Date Form
       Research Project Surveillance Procedures

LRH HREC Project Ref No. 2008-15
Appendix 3: Email from Monash Ethics Standing Committee

Monash University (Student) Mail - Monash Human Ethics - CF08/01409 - 2008000695... Page 1 of 1

Anton Isaac <anisa2@student.monash.edu>

Monash Human Ethics - CF08/01409 - 2008000695 - Approval
1 message

scher <scher@adm.monash.edu.au> 19 June 2008 16:54
To: Mark Oakley Browne <Mark.OakleyBrowne@med.monash.edu.au>
Cc: Hilton Gruss <hilton.gruss@med.monash.edu.au>, peterw@vaccho.com.au, anisa2@student.monash.edu

Dear Researchers,

This is to advise that the Standing Committee on Ethics in Research involving Humans (SCERH) has approved the above project.

Project Number: CF08/01409 - 2008000695
Project Title: Factors that facilitate and inhibit utilisation of mental health services by indigenous men in Gippsland: A case study
Chief Investigator: Prof Mark Oakley Browne

Please find attached your approval letter for this study and ensure you comply with the Terms of Approval outlined in the letter.

The Committee has asked me to convey their appreciation to all researchers, but particularly the PhD Student, for the sensitivity and compassion shown when preparing this exceptionally well thought out application.

To ensure speedy turnaround time, this correspondence is now being sent by email only. SCERH will endeavour to copy all investigators on correspondence relating to this project, but it is the responsibility of the first-named investigator to ensure that their co-investigators are aware of the content of the correspondence.

Professor Ben Canny
Chair, SCERH

Ms Coral Lindup
Senior Administrative Officer
Human Ethics Office
Building 3E, Room 111
Monash University, Clayton 3800
Phone: 9905 2076
email: scerh@adm.monash.edu.au

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2008000695 - Appr.pdf
29K

https://mail.google.com/a/student.monash.edu/?ui=2&ik=e4bbe25c2f&view=pt&cat=... 23/02/2011

180
Appendix 4: Explanatory Statements and consent forms

Project Title: Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study

This information sheet is for you to keep.

My name is Anton Isaacs and I am conducting a research project towards a PhD at Monash University. This means that I will be writing a thesis which is the equivalent of a short book. The project is being supervised by Associate Professor Priscilla Pyett from the Indigenous Health Unit of Monash University Department of Rural and Indigenous Health. I have three other supervisors whose names are listed at the end of this information sheet. I will also be guided by [cultural consultants] from the Koori community to ensure that I follow community protocols.

The aim of this research is to learn from you what might make it easier for Koori men in Gippsland to make use of Social and Emotional Wellbeing (SEWB) and mental health services, and how you would like to see the services improved. I hope that results of this study will provide information which will improve the SEWB and mental health services available for Indigenous men in Gippsland.

You have been chosen to participate in this study because I believe that you will be able to tell me about the factors that affect the use of SEWB and mental health services by Indigenous men in Gippsland.

I would like to interview you if you have used the SEWB or mental health services in Gippsland in the past, or are using them currently, or have ever wanted to use them but have not done so as yet.

What the research involves
If you agree to take part in this study, I will arrange a time to talk with you about services for social and emotional wellbeing and mental health for Koori men in Gippsland. I would like to interview you at the premises of Ramahyuck District Aboriginal Corporation in your town at a time that is convenient for both you and me. If you would rather take part in a small focus group discussion with other Koori men, I am happy to arrange that instead.

The interview will first be tape-recorded and transcribed. The transcripts will then be discussed with you to ensure that there has been no misunderstanding as well as to remove all information that could identify you. The interview or focus group discussion can take about 45-60 minutes.

During the course of the interview, you might feel stressed when talking about your experiences that were hurtful. If you feel that you are unable to continue at any time during the interview, you are most welcome to stop and perhaps continue at another time. Moreover counselling services are available at the SEWB program which you can avail.
It is entirely up to you whether you take part in this study or not and you may choose not to answer any question. If you agree to take part, you may withdraw from the study at any time up until you have given approval for me to use the interview transcript. If you choose to withdraw from the project after the interview, then the recorded information will be deleted or destroyed immediately.

All information collected for this project will be kept securely on University premises for 5 years. A report of the study may be submitted for publication, but no individuals will be identifiable in such a report.

Once the research is completed, I will be making a presentation of the findings at the Aboriginal Community Controlled Health Organisation in your town. Information from this study may also be published in a journal or presented at a conference and because it is anonymous, nobody will be named and individuals will not be identified in any way.

If you would like any further information on the study or copies of the results, please contact me on 5128 1012 or Mobile: 0432268867 or email: <anisa2@student.monash.edu.au>.

The cultural consultants for this study are:

Mr. Hugh Pepper (Dooka) - Morwell
Mr. Phil Perry - Sale
Mr. Larry Levi - Bairnsdale

The other Supervisors for this study are:
Mr Hilton Gruis (Past regional Coordinator for Gippsland of SEWB and Stolen Gen project)
Mr Peter Waples-Crowe (VACCHO)
Professor Mark Oakley Browne (Department of Health and Human Services, Tasmania)

Thank you and looking forward to your participation.

Anton N Isaacs MBBS MD
Consent Form for Interview / Focus groups – Koori men and carers

Title: “Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study”

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher □ Yes □ No
I agree to participate in a focus group discussion □ Yes □ No
I agree to allow the interview / focus group to be audio-taped □ Yes □ No

I understand that I will be given a transcript of my interview/focus group concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw from the project at any time prior to approving the interview transcript without being penalised or disadvantaged in any way. I understand that once I have approved the interview transcript, I cannot withdraw from the study.

I understand that any information that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant’s name
Signature
Date
18th May 2008

Explanatory Statement – Health care professionals, administrators and policy makers

Project Title: Factors that facilitate and inhibit utilization of mental health services by Indigenous men in Gippsland: A Case study

This information sheet is for you to keep.

My name is Anton Isaac and I am conducting a research project towards a PhD at Monash University. This means that I will be writing a thesis which is the equivalent of a short book. My principal supervisor is Associate Professor Priscilla Pyett from the Indigenous Health Unit of Monash University Department of Rural and Indigenous Health, Moe.

Why you have been chosen as a participant
You have been chosen to participate in this study because I believe that you will be able to tell me about the factors that improve and prevent the use of social and emotional wellbeing and mental health services by Indigenous men in Gippsland. I also believe that you will be able to tell me how these services could be improved.

The aim/purpose of the research
The aim of this research is to gain a better understanding of the factors that improve and prevent use of social emotional wellbeing and mental health services by Koori men in Gippsland and to suggest new and innovative models of care.

Inclusion criteria
Health care professionals including Social and Emotional Wellbeing (SEWB) workers, Aboriginal Hospital Liaison Officers, GPs, nurses, mental health specialists, health care administrators and policy makers who are directly involved in SEWB and mental health services for Koori men in Gippsland will be included in the study. Koori men from Gippsland who have used or are in need of SEWB and mental health services and their carers will also be interviewed in this study.

Possible benefits
The results of this study will propose improvements for SEWB and mental health services available for Indigenous men in Gippsland.

What the research involves
I am seeking SEWB workers, GPs, nurses, and mental health specialists who are willing to be interviewed on the topic of services for social and emotional wellbeing and mental health for Koori men in Gippsland. I also plan to interview Koori men and their carers who have utilised these services and also those who are in need of these services but have not been able to access them for any reason.

Time that the research will take
The interview can take between 15 and 45 minutes

P.T.O.
Payment
You will not receive any payment for your participation in this study.

Withdrawing from the research
Participating in this study is entirely voluntary and you are under no obligation to consent to participation. If you choose to withdraw from the project you may do so at any time.

Confidentiality
The interview will first be tape-recorded and transcribed. The transcripts will then be discussed with you to ensure that there has been no misunderstanding as well as to remove all information that could identify you.

Storage of data
Storage of the data collected will adhere to the University regulations and kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Use of data for other purposes
Data from this study may also be published in a journal or presented at a conference and because it is anonymous data, nobody will be named and participants will not be identified in any way.

Results
If you would like any further information, please contact me on 51281012 or Mobile: 0432288875 or email: <sania2@student.monash.edu.au>.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:

Associate Professor Priscilla Pyett
Indigenous Health Unit
Postal Address:
Department of Rural and Indigenous Health
School of Rural Health
Faculty of Medicine, Nursing and Health Sciences
Monash University
PO Box 973 Moe Victoria 3825 Australia
Telephone: 03 51281021; Fax: 03 51281060
Email: Priscilla.pyett@med.monash.edu.au

If you have a complaint concerning the manner in which this research CF08/1409 – 2008000886 is being conducted, please contact:

Human Ethics Officer
Standing Committee on Ethics in Research Involving Humans (SCERH)
Building 3e Room 111
Research Office
Monash University VIC 3800
Tel: +61 3 9905 2052 Fax: +61 3 9905 1420
Email: scerh@adm.monash.edu.au

Thank you.

Anton N Isaacs MBBS MD
Consent Form for Interview – Health care providers, administrators and policy makers

Title: “Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study”

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher [ ] Yes [ ] No
I agree to allow the interview to be audio-taped [ ] Yes [ ] No
I agree to make myself available for a further interview if required [ ] Yes [ ] No

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw from the project at any time prior to approving the interview transcript without being penalised or disadvantaged in any way. I understand that once I have approved of the interview transcript, I cannot withdraw from the study.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant’s name

Signature

Date
Participant Information and Consent Form

Latrobe Regional Hospital (Mental health Services)

Full Project Title: Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study

Principal Supervisor: Associate Prof. Priscilla Pyett (Monash University Department of Rural and Indigenous Health - MUDRIH)

Student Researcher (PhD): Dr. Anton Neville Isaacs (MUDRIH)

External Supervisor: Prof. Mark Oakley Browne (State wide Clinical Director, Mental Health Services, Tasmanian Government Department of Health and Human Services)

Associate Supervisor: Mr. Hilton Gruis: (Senior Lecturer, MUDRIH)

External Supervisor: Mr. Peter Wapel-Crowe (Victorian Aboriginal Community Controlled Health Organisation)

1. Introduction

You are invited to take part in this research project. Your contact details are not known to me but this form is being passed on to you by another individual on my behalf. This is because I believe that you will be able to tell me about the use of mental health services by Indigenous men in Gippsland. I also believe that you will be able to tell me how these services could be improved.

This Participant Information and Consent Form tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the procedures described

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?

This research is being conducted towards a PhD degree at Monash University and is being funded through a student scholarship.

The aim of this research is to gain a better understanding of the factors that affect the use of mental health services by Koori men in Gippsland and to suggest ways of improving the same. Research suggest that Indigenous men throughout Australia do not make enough
use of mental health services but there have been no such research studies conducted in Gippsland. I would like to hear from service providers as well as Indigenous men and their carers who are in need of mental health services. I expect there to be about 20 participants from Latrobe Regional Hospital's mental health services.

3. What does participation in this research project involve?
Participation in this research study involves taking part in a group discussion or being interviewed individually. The group discussion will take about 60 to 90 minutes and an interview will take about 30 minutes. The interviews or discussions will be conducted at a place that is convenient to you. All interviews and group discussions will be audio-taped with participants' permission.

You will not be paid for your participation in this research.

4. What are the possible benefits?
The results of this study will propose improvements for mental health services available for Indigenous men in Gippsland.

5. What are the possible risks?
There are no potential risks in participating in this study. However, if certain issues become emotionally difficult, I will be happy to discontinue the interview and continue at a later date.

6. Do I have to take part in this research project?
Participating in this study is entirely voluntary and you are under no obligation to consent to participation. However, if you do consent to participate, you may withdraw at any time.

7. How will I be informed of the final results of this research project?
The data collection phase is expected to take 12 months starting January 2009. The results of this study are expected to be published in the PhD thesis by about May 2010. Once the project is completed, a copy of the results will be provided to the participating departments. A copy of the results will also be provided to Ramahyuck District Aboriginal Corporation, Sale.

8. What will happen to information about me?
The interviews/group discussions will first be digitally recorded and transcribed. Voice recordings that have been transcribed will be destroyed immediately. It is not the intention of this research to publish voice recordings in any form. Transcriptions of interviews will be stored according to the University regulations and be kept in a locked cupboard or filing cabinet at Monash University Department of Rural and Indigenous Health for 5 years. At the end of five years, all data CDs will be destroyed once and for all. Before publication, all information identifying individuals will be removed to ensure confidentiality. The research work will be published in the thesis which will be available online from the University archives. Data from this study may also be published in a scientific journal or presented at a conference and because it is anonymous data, no one will be named and participants will not be identified in any way.

9. Can I access research information kept about me?
In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about
you. Please contact one of the researchers named at the end of this document if you would like to access your information.

10. Is this research project approved?
The ethical aspects of this research project have been approved by the Latrobe Regional Hospital (LRH) Human Research Ethics Committee as well as by the Standing Committee on Ethics in Research involving Humans (SCERH) of Monash University. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Consent
I have read this document in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received. I freely agree to participate in this research project, as described. I understand that I will be given a signed copy of this document to keep.

Participant’s name (printed) …………………………………………..
Signature Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher’s name (printed) **Dr. Anton Neville Isaacs**

Signature Date

12. Who can I contact?
If you would like any further information, please contact me on 03 **51281012** or Mobile: 0432288875 or email: <anisa2@student.monash.edu.au>.

<table>
<thead>
<tr>
<th>Principal supervisor</th>
<th>Principal supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like to contact my Principal supervisor about any aspect of this study, her contact details are given below.</td>
<td>If you have a complaint concerning the manner in which this research (HREC Ref Number. 2008-15) is being conducted, please contact the following:</td>
</tr>
<tr>
<td><strong>Associate Professor Priscilla Pyett</strong></td>
<td>Customer Services Officer</td>
</tr>
<tr>
<td>Monash University Department of Rural and Indigenous Health</td>
<td>Latrobe Regional Hospital</td>
</tr>
<tr>
<td>PO Box 973, Moe, Victoria, 3825 Australia</td>
<td>PO Box 424</td>
</tr>
<tr>
<td>Phone: 51281021</td>
<td>Traralgon VIC 3844</td>
</tr>
<tr>
<td>Fax: 51281080</td>
<td><a href="mailto:inquiry@lrh.com.au">inquiry@lrh.com.au</a></td>
</tr>
<tr>
<td>Email: <a href="mailto:priscilla.pyett@med.monash.edu.au">priscilla.pyett@med.monash.edu.au</a></td>
<td>Ph 5173 8003</td>
</tr>
</tbody>
</table>
Consent Form for Interview – Health care providers, administrators and policy makers

Title: “Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A Case study”

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

- I agree to be interviewed by the researcher [ ] Yes [ ] No
- I agree to allow the interview to be audio-taped [ ] Yes [ ] No
- I agree to make myself available for a further interview if required [ ] Yes [ ] No

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw from the project at any time prior to approving the interview transcript without being penalised or disadvantaged in any way. I understand that once I have approved of the interview transcript, I cannot withdraw from the study.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant’s name
Signature
Date
Appendix 5: Poster & Award

Factors that facilitate and inhibit utilisation of mental health services by Indigenous men in Gippsland: A case study
Anton N Isaacs; Supervisors: Oakley Browne MA¹, Pyett P², Gruis H¹, Wapes-Crowe P³
Collaborating organization: Ramahyuck District Aboriginal Corporation (RDAC), Sale, Morwell
¹Monash University Department of Rural and Indigenous Health, ²Onemore Vichi-Health Koori Health Unit, University of Melbourne, ³Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Introduction
- The state of mental health of Indigenous men in Australia is poor.
- One of the reasons for poor mental health is poor utilisation of services.
- Policies on mental health services for Indigenous people have been in place since the last decade.
- In order to improve utilisation rates, it is imperative to understand and incorporate the needs of consumers and those of their carers into services.
- No literature is available on mental health service needs of Indigenous men and their carers from Gippsland.
- Innovations with existing infrastructure could render current services more user-friendly.

Research question
What are the factors that facilitate and inhibit utilisation of available primary and secondary mental health services by Indigenous men in Gippsland?

Objectives
1. To identify the factors affecting utilisation of local Aboriginal Community Controlled Health Organisation (ACCHO) based primary care services for Social and Emotional Wellbeing (SEWB) and other primary mental health care services as perceived by Indigenous men in Gippsland.
2. To identify the factors affecting utilisation of specialist mental health services in Gippsland as perceived by Indigenous men.
3. To identify the barriers and facilitators to care for Indigenous men with mental illness as perceived by health care professionals, health care administrators and policy makers.
4. To ascertain the success/failure of current policy/service delivery structures as perceived by study participants.
5. To ascertain strategies and resources needed to address and improve access to and utilisation of mental health services by Indigenous men.

Methodology
This study will be informed by the decolonising methodology of Linda Tuhiwai Smith (1999) and the Values and Ethics Guidelines for Research with Aboriginal and Torres Strait Islander People of the National Health and Medical Research Council (NHMRC 2003). This study will also be guided by the principles of partnership of Wapes-Crowe and Pyett (2006).

Study design
The case study design will form the broad framework of this study.

Methods
Sources of data
- Indigenous men who have used or are using mental health services in Morwell, Sale and Bairnsdale
- Indigenous men who are in need of services but have not accessed services as yet
- Carers of the above groups

- Social and emotional wellbeing workers
- Health care providers - GPs, Nurses, significant others in the services, Aboriginal Hospital Liaison Officers, psychiatrists, clinical psychologists
- Health care administrators and policy makers
- Policy documents

Steps in engaging the community
- Networking with RDAC and obtaining permission to work under their auspices
- Participating in community activities
- Obtaining letters of support from cultural consultants from Indigenous communities of Morwell, Sale and Bairnsdale
- Offering to provide training to Aboriginal Health Workers
- Meeting and finalising study protocols with cultural consultants before going into the field

Expected outcomes
The study will:
1. Identify the factors affecting utilisation of both primary and specialist mental health services in the Gippsland region by Indigenous men.
2. Ascertain the successes and shortcomings of current policies and service delivery structures in Gippsland and reasons for the same.
3. Suggest consumer and carer focused improvements and innovative models to improve mental health services for Indigenous men in Gippsland.

Cultural Consultants
Hugh Pappin – Morwell
Phil Barry – Sale
Larry Levi – Bairnsdale
2008
Higher Degree by Research Student Poster Exhibition

Award for Outstanding Contribution

Presented to

Anton Isaacs
Name

Monash University Department of Rural and Indigenous Health
School

Research Matters
Monash Research Month

MONASH University
Appendix 6a: Publication 1

'What You Do is Important But How You Do it is More Important'

Engaging Indigenous Men in Rural Mental Health Services Research

Anton Neville Isaacs
MONASH UNIVERSITY

Hugh Pepper

Priscilla Pyett
UNIVERSITY OF MELBOURNE

Hilton A. Gruis
MONASH UNIVERSITY

Peter Waples-Crowe
VICTORIAN ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

Mark A. Oakley-Browne
TASMANIAN GOVERNMENT DEPARTMENT OF HEALTH AND HUMAN SERVICES

ABSTRACT

Evidence on the methods followed by non-Indigenous researchers for conducting research that involves Indigenous people in Australia is sparse. This paper describes the methodology and steps followed by a non-Indigenous researcher for engaging with men from an Aboriginal community in rural Victoria in conducting mental health services research. It describes the process adopted to initiate research and build research capacity within an Indigenous community where Indigenous researchers were unavailable and the local communities were ill-equipped to conduct research themselves. The methodology followed was informed by the values and ethics guidelines of the Australian National Health and Medical Research Council, the decolonising methodology of Linda Tuhuiwai Smith as well as methods suggested by other authors. Lessons learnt included providing for a long timeframe, which is necessary to develop relationships and trust with individuals and their Communities, adopting a flexible approach and engaging cultural advisers who represent different sections of the Community.

Keywords: Indigenous research methodology, research methods, health services research, men’s health, mental health research.

Early research involving Australian Indigenous people commenced with anthropological studies that were often intrusive, demeaning and unethical. Most did not result in any lasting benefit to the community (Henry, Dunbar, Arnott, Scrimgeour, & Murakami-Gold, 2004; Johnstone, 1991; Smith, 1999). As a result, Aboriginal and Torres Strait Islander people, like Indigenous people elsewhere, have grown to distrust research and researchers (Humphrey, 2001). Although, initially, there were no clear policies and guidelines into the conduct of research involving Australia’s Indigenous people, more recently there has been a paradigm shift in the approach to research (Henry et al., 2002; Humphrey, 2001; National Health
and Medical Research Council, 2003; Smith, 1999). Nonetheless, literature on Indigenous health research methodology when conducted by non-Indigenous researchers continues to be sparse.

Over the last decade, much has changed in the area of Indigenous research. Two reports, We Don’t Like Research, published in 2000, and We Can Like Research, published in 2008, highlight this development (Onemda VicHealth Koori Health Unit, 2008; VicHealth Koori Health Research and Community Development Unit, 2000). The 2008 report highlights the need for Indigenous people to initiate and control research that involves them. However, there continues to be many Indigenous communities where Indigenous researchers are unavailable and Indigenous communities are either ill-equipped to initiate research themselves or their interest in research needs to be cultivated (Onemda VicHealth Koori Health Unit, 2008). In such situations, research can still be conducted by building ‘strong partnerships between the Community, ACCHOs, research organisations and researchers’, as recommended by the Victorian Aboriginal Community Controlled Health Organisation’s Strategic Directions Report for the Social Determinants of Aboriginal Health Project (Watson, Adams, Fredericks, & Mahoney, 2010, p. 9).

This paper is part of a doctoral thesis and describes the methodology adopted by a non-Indigenous student researcher to engage with the Koori population in three towns in rural Victoria. Throughout his study period, and in co-authoring this paper, the student researcher was supported by two Indigenous advisers, one of whom was a formal cultural adviser and the other a co-supervisor. This paper highlights the lessons learnt by the student researcher (who is henceforth referred to as ‘the researcher’) in carrying out this methodology. The research was informed by the decolonising methodology proposed by Maori academic Linda Tuhiwai Smith as well as the Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research, published by the Australian National Health and Medical Research Council (NHMRC) (National Health and Medical Research Council, 2003; Smith, 1999). Lessons learnt by other researchers who have conducted Indigenous health research in Australia have also been employed (Henry et al., 2002; Pyett, Waples-Crowe, & van der Sterren, 2009; Waples-Crowe & Pyett, 2005). Smith (1999) states that ‘Indigenous methodologies tend to approach cultural protocols, values and behaviours as an integral part of methodology’ (p. 15). This paper describes methodology from this Indigenous perspective and it is hoped that it will provide some practical steps particularly for non-Indigenous researchers conducting research among Indigenous communities (see Table 1).
Table 1: Value-based Steps Followed by a Non-Indigenous Student Researcher in Engagement with an Aboriginal Community in Rural Victoria

<table>
<thead>
<tr>
<th>Steps followed</th>
<th>Value</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Familiarised himself with Aboriginal history and culture and received training in cultural competence</td>
<td>Survival and Protection</td>
<td>Year 1</td>
</tr>
<tr>
<td>2 Confirmed area of research need by consultation with the Koori community/Indigenous experts in the field</td>
<td>Responsibility</td>
<td>Year 1</td>
</tr>
<tr>
<td>Identified a promoter for the introduction of the researcher to the Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtained support in the form of supervision from an Indigenous and non-Indigenous researcher from VACCHO</td>
<td>Equality</td>
<td>Year 1</td>
</tr>
<tr>
<td>3 Identified partners and formalised partnerships with the Indigenous community involved in the research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtained formal support from the ACCCH that would support the research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified and obtained formal support from cultural advisers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied for and obtained Ethical Clearance for the study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Began the process of ‘cultural immersion’ to get to know the Community and allow the Community to get to know the researcher</td>
<td>Spirit and Integrity</td>
<td>Year 2</td>
</tr>
<tr>
<td>5 Gradually built trust through informal interactions with the Community</td>
<td>Respect</td>
<td>Year 3</td>
</tr>
<tr>
<td>(‘Teamwork while working in the community’)</td>
<td></td>
<td></td>
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<tr>
<td>Recruited participants for the study using snowball sampling</td>
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<tr>
<td>6 Gave back to the Community by:</td>
<td>Reciprocity</td>
<td>Years 2, 3 and 4</td>
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<tr>
<td>conducting training on ‘Basics of Counselling’ for the SEWB workers</td>
<td>Respect</td>
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<td>acknowledging participant contributions in publications and presenting them with copies of the work</td>
<td>Equality</td>
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<td>avoiding misinterpretation of meaning by ‘respondent validation’</td>
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BACKGROUND OF THE STUDENT RESEARCHER

The researcher’s interest in Indigenous mental health grows from his previous experience in community mental health in India and his own Anglo-Indian culture. He is an overseas trained public health physician with previous experience in developing and running a rural mental health service in South India (Isac, Neerakkal, Srirvivasan, & Jayaram, 2006). The researcher belongs to the Anglo-Indian community, which is a direct outcome of the European colonisation of India and, in belonging to a minority community, he has a subjective understanding of issues around race and identity. This background has enabled him to better understand Australian Indigenous people and, in particular, the Koori people of Victoria.
RESEARCHER’S INTRODUCTION TO ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The NHMRC states that research involving Aboriginal and Torres Strait Islander people should be guided by a set of core values. One of those values is Survival and Protection. This value highlights the need for the researcher to be aware of the history of Aboriginal and Torres Strait Islander peoples and respect their social cohesion and cultural distinctiveness (National Health and Medical Research Council, 2003). Being an international student with no previous exposure to Aboriginal and Torres Strait Islander people, it was necessary for the researcher to get to know the Community, the people and what they stood for.

The researcher obtained an introduction to the history, images and artwork of Koori people through a visit to the Koorie Heritage Trust in Melbourne. He then attended training programs on cultural competence both at the university as well as externally (Indigenous Psychological Services, 2004–2011; National Health and Medical Research Council, 2003; Waples-Crowe & Pyett, 2005; Westerman, 2004). Through teaching Indigenous health to university students, together with informal discussions with knowledgeable members in the field, he educated himself about the history of Australia’s Indigenous people. He was also invited to accompany a group of university students for a period of ‘cultural immersion training’ (Fielke, Cord-Udy, Buxton, & Lattanzio, 2009) where he stayed with the Adnyamathanha people in South Australia and learned from their Elders about their dreaming stories and songs and dances of their culture. While these introductions did not provide the researcher with specific knowledge of the Victorian community that was to be researched, it still gave the researcher a broad introduction and valuable insight into Australian Aboriginal people and their history.

IN Volving THE COMMUNITY IN DECIDING THE FOCUS OF RESEARCH

From the literature, it was evident that mental health problems are common among Indigenous people (Berry & Crowe, 2009; Hunter, 2003; Swan & Raphael, 1995) and that Indigenous people with a mental illness are reluctant to access mainstream mental health services. Whilst this is largely thought to be due to cultural inappropriateness of services, (Kowanko, Crespin, Murray, Groenjager, & Emden, 2004; Wenitong, 2002; Westerman, 2004), little is known about help-seeking among Indigenous people with mental health problems. Additionally, mental health services in the study area are coordinated by a single regional hospital through community mental health centres spread across the region. Therefore, we felt it would be feasible to focus the research on help-seeking behaviour for mental health problems and development of strategies to render mental health services more user-friendly for Indigenous people. With this background information, the researcher met with key Indigenous persons from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) who are involved in mental health and social and emotional wellbeing (SEWB) programs. In addition to supporting the proposal, one Indigenous and one non-Indigenous researcher from VACCHO agreed to co-supervise the research. An early outcome of these discussions was the decision that being a male, it would be culturally appropriate for the researcher to confine the research to Indigenous men.

We also consulted with the Regional Coordinator of the SEWB program and the staff of the Aboriginal Community Controlled Health Organisation (ACCHO) in the region. Another factor that contributed to deciding the focus of this research was that the then
Director of psychiatric services at the regional hospital was also keen on supporting the research. After consultation with all parties concerned, it was decided that the research would study help-seeking among Indigenous men with mental health problems and the factors that influence their utilisation of mental health services. Therefore, the aim of the research was to improve mental health services for Indigenous men. In-depth interviews and focus groups were to be conducted with participants who included staff from the community mental health services, Indigenous SEWB workers and Indigenous men and carers.

**EARLY CONSULTATIONS WITH THE COMMUNITY AND IDENTIFYING CULTURAL ADVISERS**

A number of authors have stressed the need to begin consultations with the Community involved in the research before the research proposal is developed (see Pyett et al., 2009; Wand & Eades, 2008). One of the supervisors of the study acted as the promoter of the research. His role as promoter was significant due to his previous experience as the Regional Coordinator of the SEWB program where he had developed important networks and working relationships with all Aboriginal communities and their respective organisations within the region. The promoter was the key to setting the foundation for the research work. At the outset, he introduced the researcher to the CEO of the ACCHO and to other significant members of the Koori community, and discussed the proposed study with them in order to obtain their opinion as well as advice on how to go about the study (Henderson, Simmons, Bourke, & Muir, 2002). While discussing the proposed research with Community members, an Elder poignantly remarked, ‘What you do is important but how you do it is more important.’

It is frequently suggested that research be overseen by a steering committee consisting of Aboriginal Elders and other significant members of the community (Henderson et al., 2002; Pyett et al., 2009). When asked for advice regarding a steering committee, the CEO of the local ACCHO suggested that it would be more feasible to have cultural advisers (CAs) who could be contacted individually for advice and guidance. As part of giving back to the community, the researcher offered to conduct education sessions for the staff of the ACCHO as well as for the general community on any aspect of health, including mental health.

One CA was chosen from each of the three key service areas in the region. All three agreed to support the study by recruiting participants and providing guidance on engagement with the Community. Later, formal letters of support were received from each of them. One of them is a co-author of this paper. Ethics approval was obtained from Monash University’s Standing Committee on Ethics in Research Involving Humans and from the regional hospital’s Human Research Ethics Committee.

**‘LEARNING WHILE WORKING IN THE COMMUNITY’ AND RECRUITMENT OF PARTICIPANTS**

Snowball sampling was used to recruit participants (Patton, 2002). Although CAs had initially agreed to introduce the researcher to potential participants, the process took a long time. Recruitment took place mostly during Community gatherings, where Koori men surrounded by their own people felt comfortable enough to talk to outsiders. Such gatherings were infrequent. They usually occurred during NAIDOC week celebrations (National Aborigines and Islanders Day Observance Committee week is celebrated in the first full week in July
each year 'to celebrate the history, culture and achievements of Aboriginal and Torres Strait Islander people') and during the week of the Walks for Reconciliation (organised by Koori communities during National Reconciliation Week, which is held between 27 May and 3 June every year) to support action towards reconciliation between Indigenous and non-Indigenous people in Australia (NAIDOC 2011; Reconciliation Australia 2010). The process of recruitment at some of these events is discussed below. Community members who had enough time to get to know the researcher were more forthcoming about participating than others.

One CA advised that in order to recruit participants for the study, the researcher needed to attend Community gatherings. This process has been described as 'learning while working in the community' where the researcher participates in community life and events in order to develop social skills and understanding of the Community’s culture (Pyett, Waples-Crowe, & van der Sterren, 2008). The researcher therefore attended every get-together of the local Aboriginal community that he was invited to and made multiple courtesy calls to the different services run by the ACCHO. The promoter initially accompanied the researcher on these visits until he felt comfortable going on his own.

The process of engaging with the Community was slow and occasionally bumpy. In the second year of the research, the researcher was invited to the flag-raising ceremony for NAIDOC celebrations at the local Koori meeting place. Having arrived at the venue early and noticing that his CA had not yet arrived, he walked up to a group of Koori men and introduced himself. In no time, all of them departed, save one, who then said to him:

You see all of them walked away? You never walk into a group of Koori men and talk to them unless you know them. Stand aside and wait until they call you. Koori people will never talk to you unless they know you. Remember this always.

To ensure that his interview questions were sensitive and appropriate, the researcher conducted practice interviews with his CAs. Although the three CAs had approved of the explanatory statement prepared specifically for Indigenous participants, practice interviews helped the CAs to better understand what the process was about and gave them more confidence in introducing the researcher to other men. During the course of the next twelve months, the researcher attended many funerals, had multiple meetings with his CAs and recruited a few more men for the study. On the invitation of the ACCHO, the researcher also conducted a basic course on counselling for their SEWB and drug and alcohol workers, which was well received. As part of the research, the researcher had incorporated artwork of a local Koori artist in a poster for which he won a prize. A copy of the poster was formally presented to the artist in the presence of his CA and another Elder. Each of these activities demonstrates the core values of Reciprocity, Respect and Equality (National Health and Medical Research Council, 2003).

An invitation to a men's golf day outing in the second year had provided a promising opportunity for the researcher to meet and recruit men for the study. However, heavy rain led to its cancellation and it was another 12 months before the event was rescheduled and the researcher was able to attend. By this time, he had developed a friendship with his CA. Since the researcher had not played golf before, he was given his first lessons by a Community Elder, and in playing as part of a team he was touched by their generosity, patience and encouragement. Following the game, as the researcher was about to leave, his CA invited him to the cultural program scheduled for the following day. He said, 'Come if you can. You are part of the Community now and you know that the doors are always open'. Another
sign of his acceptance was when men held their hand up to lock his in a 'Koori handshake', which the researcher learnt from an Elder.

The researcher made regular phone calls to his CAs to enquire about potential participants. During one such call, his CA asked him to drive over to a local park where a Koori expo was taking place. There was a gathering of about 200 members of the community there and he introduced the researcher to a few men who agreed to be interviewed. On another occasion, the researcher was invited to participate in the Reconciliation Walk. At the end of the walk, while people were having their barbecue lunch, his CA introduced him to a group of men who readily agreed to participate, giving him their phone numbers. One of the men was a local Elder. At the end of the interview with this Elder, which was conducted later, he suggested that he would accompany the researcher to some houses and talk to people whom he knew. He said that his presence would enable the men to feel comfortable talking about their problems. Two men were recruited that way. Three others were not home that day. One male Elder who agreed to participate was unable to keep his appointments on three occasions because of deaths and funerals.

A total of 12 Indigenous men and carers were recruited for the study, most of whom were from the one community (17 km from where the university department is located). Recruitment was less successful in the two communities that were further away from the university (81 km and 149 km) and in situations where people did not get enough time to be acquainted with the researcher.

**DISCUSSION**

Conducting field research within Aboriginal communities can be quite challenging, especially when initiated and carried out by a researcher who is non-Indigenous and an outsider. This paper has demonstrated that research of this nature is possible when the researcher is able to exhibit a culturally appropriate and sensitive attitude towards the research, adheres to the right values and protocols and is respectful to the Koori community. The research demonstrates reflexivity, which is an important prerequisite for Indigenous research (Henry et al., 2002; Nicholls, 2009). The researcher demonstrated that he learned from his CAs and the Koori community to be patient and flexible, utilising opportunities that were presented by invitations to Community events. The promoter played a major role in introducing the researcher to the Community.

Although the authors had taken all precautions to ensure that the research was respectful, recruitment of participants in two Communities was less than ideal. This was primarily due to the lack of time, an issue raised by other authors as well (Couzos, Lea, Murray, & Culhong, 2005; Mayo, Tsery, & Empowerment Research Team, 2009; Shahid, Bessarab, Howat & Thompson, 2009). Providing an adequate time frame for the research allows for a relationship to be built between the researcher and the Indigenous community (Waples-Crowe & Pyett, 2005; Mayo et al., 2009). For a community-based research project of this size and scope and involving Indigenous communities with little research experience, we feel that five years would be an adequate time frame rather than the three years allocated to a PhD project. Another likely reason for recruitment difficulties was the stigma usually associated with mental health problems, which is intensified in Indigenous communities where 'shame' exacerbates peoples' reluctance to discuss such private matters with service providers, or other outsiders such as researchers.
CAs were an integral part of this study. Without their support and encouragement, this study would not have been possible. One of the shortcomings of this research was the inadequate number of CAs. We learnt that it would have been useful to have more than one CA for each Community. The CAs in this project did not receive any reimbursements for their time and effort. Since CAs are otherwise busy people, advising student research presented an additional burden without financial or other reward (Shahid et al., 2009). Community Elders, in particular, who accept the role of a CA, bring with them a vast body of experience that could significantly enrich the research process. Perhaps, if they were considered part of the supervisory team and made eligible for remuneration, just as their academic counterparts, the research would demonstrate more Equality.

In order to be accepted by the Community, the researcher needs to first be accepted by the CAs and develop a relationship with them. That requires patience and flexibility, qualities that will go a long way in engaging with the Community as well. Repeated postponements of appointments must be accepted by researchers, as family and community gatherings as well as funerals are a priority for Koori people. Crespigny and colleagues have also noted that flexibility was a key factor in their success with developing partnerships for Indigenous research (Crespigny, Emden, Kovaniko, & Murray, 2004). Since this was the first time research involving cultural advisers was carried out in our study region, they required time to determine that the researcher was respectful and that the research was outcome-oriented before committing to engage with the researcher and the research process. Once the process of recruitment and interviews commenced, participants generally discussed their experience of the researcher with the CA. CAs relied on participant feedback to reassure them that the research process not only did no harm but was also of benefit to the Community. This was also an opportunity for the CAs to learn about the research process.

A useful way of getting to know the Community is by attending gatherings such as those that take place during NAIDOC week celebrations. One needs to approach the research with respect, understanding and empathy for what Koori people have endured over the years. In engaging with Koori people, one also learns the value of humour, which is an endearing characteristic of their culture and a mark of their resilience and survival. Koori people are a good judge of character and integrity in a person because as one of the CAs stated, ‘They have had to do it all their lives to figure out where they stood with outsiders’. Respect is a very important value in the Koori community and the researcher needs to demonstrate this at all times. Furthermore, when discussing sensitive issues such as mental health with men, a little smile or the ability to share a laugh with them can go a long way in developing mutual trust.

CONCLUSION

This paper gives a detailed description of how a non-Indigenous researcher built a research relationship with an Indigenous community, starting from early consultations to writing up a collaborative research paper with two Indigenous co-authors. It highlights some key elements that non-Indigenous researchers need to consider when conducting research involving Indigenous men. They include providing for a long time frame for the research, obtaining the help of an appropriate promoter to facilitate introductions to the community, identifying the right cultural advisers and being flexible and respectful at all times. It is hoped that the processes set up and the partnerships developed through this research will pave the way for long-term collaborations focused on improving Indigenous health and wellbeing in the region.
More culturally appropriate research that takes care of the aspirations and needs of Aboriginal people will go a long way in changing their opinion of research and perhaps even encourage them to embrace it.

**ACKNOWLEDGEMENTS**

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**NOTES**

1. An Aboriginal community includes country (land), family ties, belonging and shared experiences of Aboriginal people. The term ‘Community’ has been used with a capital C when it refers to this context.
2. In this paper, the term ‘Indigenous’ is used interchangeably with ‘Aboriginal and Torres Strait Islander’.
3. Koort (also spelled ‘Koorie’) refers to the Aboriginal people of Victoria and south-eastern Australia.

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Appendix 6b: Publication 2

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FEATURE ARTICLE

Barriers and facilitators to the utilization of adult mental health services by Australia’s Indigenous people: Seeking a way forward

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ABSTRACT: Mental disorders are the second leading cause of disease burden among Australia’s Indigenous people after cardiovascular disease. Yet Indigenous people do not access mental health services in proportion to their need. This paper explores the barriers and facilitators for Indigenous people seeking mental health services in Australia and identifies key elements in the development and maintenance of partnerships for improved service delivery and future research. The process of seeking help for mental illness has been conceptualized as four consecutive steps starting from recognizing that there is a problem to actually contacting the mental health service. We have attempted to explore the factors affecting each of these stages. While people in the general population experience barriers across all four stages of the process of seeking treatment for a mental disorder, there are many more barriers for Indigenous people at the stage of actually contacting a mental health service. These include a history of racism and discrimination and resultant lack of trust in mainstream services, misunderstandings due to cultural and language differences, and inadequate measures to reduce the stigma associated with mental illness. Further research is required to understand the mental health literacy of Indigenous people, their different perceptions of mental health and well-being, issues around stigma, and the natural history of mental illness among Indigenous people who do not access any form of professional help. Collaborations between mainstream mental health services and Aboriginal organizations have been promoted as a way to conduct research into developing appropriate services for Indigenous people.

KEY WORDS: Aboriginal and Torres Strait Islander people, barrier, facilitator, mental health service, utilization.

INTRODUCTION

Mental illness is widespread among Indigenous people in Australia (Hunter 2003; Swan & Raphael 1995). Mental disorders are reported to be the leading cause of disease burden among Indigenous people after cardiovascular

2In this paper, the term ‘Indigenous’ is used interchangeably with ‘Aboriginal’ to refer to the Aboriginal and Torres Strait Islander people of Australia.

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disease and are responsible for 15% of the total disability adjusted life years (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2008). This is also reflected in hospital separations data, which show that Indigenous people who had a principal diagnosis of mental and behavioural disorders were admitted at 1.8 times the rate for non-Indigenous people (Australian Institute of Health and Welfare 2008). Mental disorders are also identified as a major cause of mortality through suicide, and rates of mortality due to suicide in Indigenous people are twice that for the general population (Australian Institute of Health and Welfare 2008). A survey in Adelaide of the ‘next of kin’ of Aboriginal suicide victims found that 35% of these suicide victims had a mental health problem (Aboriginal Health Organization & The Mental Health Research and Evaluation Centre 1991).

The reasons for this alarming state of mental health are multiple. Indigenous people cite a combination of factors that are responsible for their poor mental health, which include lack of employment, family violence, past government practices of removal from family (‘stolen generations’), substance abuse, and poverty (Emeis et al. 2005; O’Brien 2005; Vicary & Bishop 2005). Their descriptions of ill health are invariably dovetailed with accounts of loss of land, family and culture, and of exclusion from ‘full participation in the social, political and economic life of post-invasion Australia’ (Saggers & Gray 2007).

Another determinant of the poor mental health status of Indigenous people is their suboptimal utilization of services. Indigenous people do not access available mental health services in proportion to their need (Westernman 2004). In the aforementioned Adelaide survey, only 14% of the Aboriginal people who had a diagnosable mental illness at the time of their suicide had sought treatment for their illness (Aboriginal Health Organization & The Mental Health Research and Evaluation Centre 1991). The 1996 National Standards for Mental Health Services stipulates that services should investigate underutilization by Indigenous people (Australian Health Minister’s Advisory Council’s National Mental Health Working Group 1996). This paper explores the barriers and facilitators for Indigenous people in Australia seeking mental health services and identifies key elements in the development and maintenance of partnerships for improved service delivery and future research.

MENTAL HEALTH SERVICES FOR INDIGENOUS PEOPLE

Since 1998, Aboriginal Community Controlled Health Services (ACCHS) across Australia have been assigned to serve as the hub of health services, including mental health and social and emotional well-being (SEWB) services, for the Indigenous community (Australian National Audit Office 1998). Hunter (2007) points out that the SBWB model of mental health services adopted by ACCHS improves access to and the responsiveness of care for Indigenous people and is better suited to them than the mainstream model of treatment-oriented services. However, in an evaluation of ACCHS-based Indigenous mental health programmes, some limitations of these services were identified, which result in an ongoing unmet need for services (Wilczynski et al. 2007).

Mainstream mental health services are often the only services available to Aboriginal and Torres Strait Islander people. State mental health services for adults include crisis management, mobile support and treatment, continuing care, inpatient services, primary mental health, and early intervention (Ash et al. 2007). However, Aboriginal and Torres Strait Islander people find it difficult and sometimes distressing to access these services (McKendrick 2000; Social Health Reference Group 2004; Vicary & Westernman 2004). The process of seeking help for mental illness has been conceptualized as four consecutive steps: realizing that there is a problem, deciding that treatment is necessary to solve the problem, deciding to seek treatment, and contacting the mental health service (Saunders 1993). Factors affecting each of the steps in the process of seeking mental health services by Indigenous people are discussed below (Table 1).

RECOGNIZING THE PROBLEM

Aboriginal people have a holistic view of health, and their concepts of mental health differ from that of the mainstream population. Mental health is considered to be an interaction between the individual, the community, and the environment, involving spiritual, social, cultural, physical, and mental well-being and issues related to land and way of life (Swan & Raphael 1995). Aboriginal and Torres Strait Islander people are not a homogenous group and there are therefore many different perceptions of mental illness among them. For example, in some parts of Australia, mental illness can be perceived as ‘payback’ for past transgressions or even being ‘married the wrong way’ (Vicary & Bishop 2005). Vicary and Westernman (2004) draw attention to the fact that in certain communities high prevalence disorders, like depression, are not perceived as treatable conditions by Aboriginal people, who describe depression-like symptoms as a characteristic of the individual and refer to the condition as ‘that’s just the way he is’ (Vicary & Westernman 2004). Research suggests...
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<th>Stages</th>
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<td>Recognizing the problem</td>
<td>Poor mental health literacy</td>
<td>Mental health awareness programmes in the community</td>
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<td>Different concepts of mental health and well-being</td>
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<td>Deciding to seek</td>
<td>'Shame factor'/stigma</td>
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<td>Giving a culturally-appropriate name for the service</td>
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<td>Display of more visual images and Aboriginal art in the clinics</td>
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<td>Employment of Indigenous staff and Aboriginal mental health workers</td>
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<td>Family relationships to clinic staff (where Aboriginal staff are hired)</td>
<td>Provision of outreach services</td>
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<td>Gender issues – need to see same sex service provider</td>
<td>Providing transport, especially in rural and remote areas</td>
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<td>Distance to appropriate service</td>
<td>Establishing close ties between community and mainstream services</td>
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<td>Fear of hospitalization far away from family and 'fear of being locked up'</td>
<td>Cross-cultural training</td>
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<td>Denial of treatment and wrong diagnosis</td>
<td>Clinicians have an understanding of language, family, and tribal groups</td>
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<td>Refusen to talk to non-Aboriginal counselors</td>
<td>Involvement of traditional methods of resolving mental health problems,</td>
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<td>Differences in the use of language</td>
<td>including traditional healers and other community members</td>
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<td>Staff ignorance of Indigenous culture, languages, and current life</td>
<td>Use of easy-to-understand language</td>
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<td>circumstances leading to practices that are</td>
<td>Cultural supervision of staff by community elders</td>
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that even when individuals recognize that there is a problem, they may not attribute it to mental illness (Whitt & Meille 1995). Furthermore, mental health literacy in the general population is reported to be suboptimal (Jorn et al. 2007). It is therefore likely that awareness regarding mental health is also low within the Indigenous population. However, the evidence is sparse in this area. Bley et al. (2007) report that Indigenous clients and their family members stated that they did not fully understand mental illness. There is no evidence so far on whether programmes to improve mental health literacy among Indigenous people would improve service use.

**DECIDING THAT MENTAL HEALTH SERVICES COULD HELP**

Once an individual recognizes that a problem exists, the next step is to decide whether seeking professional mental health help could solve the problem. Nevertheless, this process is not automatic (Saunders 1993). Describing traditional mental health treatments of Aboriginal people in Western Australia, Vicary and Bishop explain that mental illness among Aboriginal people is first managed by the family, and if this fails, the extended family is involved and later the community elders, if needed. If the situation turns out to be very difficult, the patient might be referred to the family’s traditional healer through a third person (Vicary & Bishop 2005). In most cases, people with severe forms of illness who have exhausted the resources of the family and community and who have high levels of distress reach mainstream services (Briac 2001; Westerner 2004). Therefore, it is likely that a substantial number of Aboriginal people with less severe ‘mental health problems’ either endure their illness or adopt some form of coping strategy while not receiving any kind of professional help. This group represents the unmet need for services. Further research is needed to understand what happens to this group. The decision that professional help is necessary is usually influenced by informal support networks.
such as family and friends (Saunders 1993). This support network can promote or hinder access to professional mental health services. If the support group strongly feels that the problem is due to life stresses and that there is no need for formal help, it becomes all the more difficult for individuals to seek professional help.

Research in the general Australian population also indicates that not everyone with a mental illness utilizes treatment. Meadows and Burgess report that 88% of those with a mental disorder who were not receiving treatment said that they did not need any type of help (Meadows & Burgess 2009). However, the reasons for this phenomenon are not clear (Henderson et al. 2006). Poverty is another barrier to seeking treatment for mental illness, where people do not have the luxury of taking care of their health needs because they are preoccupied with meeting their basic needs, such as food and housing (Commonwealth Department of Health and Aged Care 2001; Fan 2007; Mayo et al. 2009).

DECIDING TO SEEK TREATMENT

Other factors that can hinder making the decision to seek treatment include the stigma associated with mental illness (Saunders 1993). Reports suggest that the ‘shame factor’ or stigma prevents Indigenous people from accessing mental health services (Briscoe 2000; Eley et al. 2007). Corrigan (2004) describes stigma as having two components: ‘public’ and ‘self-stigma’. He notes that when the public attaches a stereotype to individuals with mental illness and proceeds to discriminate against them, those who believe they have a mental illness shield themselves from this discrimination by hiding their illness and avoiding visiting mental health services. Strategies identified to combat stigma include education of the public and contact with people with mental illness who are able to keep their jobs and are productive members of society (Corrigan 2004). Destigmatizing mental health services by using culturally-appropriate names for services has been reported to improve acceptance by Indigenous people (Salaberry 1998). Indigenous people also indicate that they have a ‘fear of being locked up’ when admitted to a psychiatric hospital (Eley et al. 2007). It would therefore be necessary to incorporate messages that help alleviate this fear when designing mental health awareness programmes for Indigenous people. Gender is another factor that influences this stage of treatment seeking. Indigenous men access services far less than females, perceiving clinics as a ‘woman’s place’ (Wenitong 2002).

CONTACTING THE MENTAL HEALTH SERVICE

Deciding to seek treatment is distinct from actually contacting the service (Saunders 1993). In the general population, once individuals decide that treatment is necessary, the next stages ensue rather quickly, for Indigenous people, the barriers at this stage are multiple (Table 1). A general lack of trust in mainstream services by the Indigenous community and previous experiences of racism and discrimination can draw individuals away from these services (Eley et al. 2007; Henry et al. 2004; McKendrick 2007; Wenitong 2002). Indigenous staff and Aboriginal health workers who are active in their communities and are employed in mainstream mental health services help to remove the misconceptions associated with those services and can provide a key role in boosting the confidence of clients within the service, as well as acting as cultural advisors to non-Indigenous service providers (Eley et al. 2007; McKendrick et al. 1999; Nagel & Thompson 2006; Norris et al. 2007). In Melbourne, McKendrick et al. (1999) reported an increased utilization of mental health services by Aboriginal people following the development of a mental health network employing, among others, two Aboriginal mental health workers and one Aboriginal research officer. A local Indigenous community consultation unit enabled liaison between the medical staff and the Aboriginal consultants, thus ensuring greater convenience for clients and promoting a strong sense of identity for the service as being appropriate for Aboriginal people. Employing Indigenous staff in mental health services can have disadvantages since many communities are small and close knit and Indigenous people might find it difficult to use a service when they are related to the staff (Wenitong 2002).

The involvement of community elders and traditional practitioners in service provision has also been found to be valuable. A senior psychiatric registrar who worked in central Australia noted that it was helpful to ‘work in parallel’ with Ngangkars (traditional healers in central Australia) and that they did not ‘undermine’ his work. He further went on to say that ‘the strongest medicine is when white fella and black fella ways are used together’ (Sheldon 2001). Fielske and colleagues note that the involvement of Ngangkars in mental health services is more common in rural areas of South Australia than in metropolitan services, and that such involvement was more on a one-off basis with no clear protocol for regular engagement in place (Fielske et al. 2000).

Several barriers are associated with differences in culture and a lack of understanding thereof. For instance,
Indigenous people are not comfortable talking to individuals of the opposite sex about their illness (Sheldon 2001; Wenitong 2002). Where possible, it is more acceptable for Indigenous people to be assessed by individuals of the same sex (Wenitong 2002; Westerna 2004). Indigenous people who use English as a second or third language can find it difficult to understand the language used by service providers (Eley et al. 2006, 2007). Differences in culture, epistemologies, and language can result in making incorrect diagnoses and using practices that are considered offensive (McKendrick 2007). Cross-cultural training of service providers on the mental health needs of Indigenous people along with an appreciation of their pre- and post-colonial history and culture could enable better understanding of their Indigenous clients and modify attitudes towards them (Eley et al. 2007; Social Health Reference Group 2004). However, for cross-cultural training to be meaningful and not just tokenistic, the community that is being served needs to be involved to ensure that appropriate protocols are used.

"Institutional racism", where racist beliefs and practices are entrenched into the functioning of institutions, continues to exist in Australia (Henry et al. 2004). Addressing issues around racism is not straightforward. However, certain measures have been reported as being useful in rendering the service Indigenous friendly. When service providers interact with the Aboriginal community in a non-professional environment, the latter get to know the former better and this can promote trust in the service (Westerna 2004; Cowton et al. 2007), while studying the involvement of deprived communities to improve primary health-care services in Scotland, indicate that the 'approachability' of health service staff is an important factor in determining access to services. They further state that the 'social distance' between staff and clients precluded the former from taking into consideration the harsh realities of poverty that their clients had to encounter on a daily basis. Indigenous people look for something 'to identify with' in the clinic, and displaying Aboriginal posters and art on the walls makes them feel more comfortable and also promotes trust in the mainstream service (Hayman et al. 2006; Teasdale et al. 2008).

Other factors reported to be barriers to seeking treatment from mental health services by Indigenous people include a lack of round-the-clock services (Eley & Hunter 2006; Salisbury 1998), long waiting times, problems with Medicare cards (Wenitong 2002), and a lack of transport, especially in rural and remote areas where there are great distances to services (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2008).

SEEKING A WAY FORWARD

Although there are many factors that inhibit utilization of mental health services by Australian Indigenous people, it is not clear from the available literature which factors warrant the highest priority in terms of planning interventions. Sound empirical research is needed to identify the perceived mental health needs of the diverse communities of Indigenous people across Australia. This research needs to take into account that delivery of mental health services is not uniform across all Australian states and territories (Ash et al. 2007). Culturally-appropriate and locally-relevant research to improve services for Indigenous people needs to be conducted through partnerships between Aboriginal organizations, area mental health services, and educational institutions. Research is also required to understand the mental health literacy of Indigenous people, their different perceptions of mental health and well-being, issues around stigma, and the natural history of mental illness among Indigenous people who do not access any form of professional help.

'WHITE FELLA AND BLACK FELLA' WORKING TOGETHER: BUILDING PARTNERSHIPS FOR SERVICE DELIVERY AND RESEARCH

Building strong relationships with the Aboriginal community has been identified as central to developing an effective service (Champion et al. 2008; Cooper et al. 2007). The 1996 National Standards for Mental Health Services, National Mental Health Plan 2003–2008, and The National Strategic Framework for the Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Well Being 2004–2009 have all recommended collaborations between mainstream services and ACCHSs in developing innovative and culturally-appropriate services for Aboriginal and Torres Strait Islander people (Australian Health Minister’s Advisory Council’s National Mental Health Working Group 1996; Australian Health Ministers 2003; Social Health Reference Group 2004). There is also a need for the strengthening of ACCHSs through the capacity building of Indigenous communities and through increasing funding for better infrastructure and increased workforce (Social Health Reference Group 2004). Although government policies have gone some way towards addressing the unique mental health and SEWB needs of Indigenous people, implementation of these initiatives has been slow, resulting in little improvement in the mental health and well-being of Indigenous people over the last decade.
(Menachov 2008). Progress is better and more swiftly achieved when there is a successful collaboration between, governments, community mental health services, and ACCHS.

The Australian Integrated Mental Health Initiative is an example of collaboration between Aboriginal organizations, mainstream health services, and tertiary education institutions (Nagle 2004). Other instances of collaboration in developing appropriate mental health services for Indigenous people have been documented with substantial success (Eley et al. 2006, 2007; Fuller et al. 2005; Langham et al. 2002; Teachdale et al. 2008; Toowoomba District mental Health Service 2003). An important prerequisite for these partnerships is the relationship between key individuals (Fuller et al. 2005; Menachov 2008). Productive research collaborations must be built on ‘sensitivity’, ‘reciprocity’, ‘respect’, and ‘equality’ (National Health and Medical Research Council 2003; Pyett et al. 2008). Describing an innovative mental health network and successful collaborative programme between an Aboriginal community and an academic unit in Victoria, McKendrick et al. (1990) note that effective partnerships need ‘goodwill and a preparedness to work through difficult issues’. Fuller et al. (2005) point out that establishing and maintaining these partnerships are of prime importance and might warrant employment of individuals to work solely on building and maintaining networks. Waples-Crowe & Pyett (2005) describe the elements of a successful partnership between Indigenous communities and non-Indigenous institutions that include valuing each other, building trust, formalizing partnerships, and providing supportive environments. Furthermore, while reflecting on a research collaboration between an Aboriginal community and a university, Mayo et al. (2006) state that if the collaboration recognizes the community’s priorities and incorporates the principles of community consultation, capacity building, transparency, and patience among others, the initial scepticism would give way to ‘positive experiences’. They also reiterate that building such collaborations requires commitment and time.

CONCLUSION

There is an urgent need to reduce the burden of mental illness in Australia’s Aboriginal and Torres Strait Islander communities. There is clearly much to be done in implementing national policy for more culturally-appropriate Indigenous mental health services. This paper has explored current understanding of factors that influence utilization of mental health services by Indigenous people in Australia. A key finding is that while people in the general population experience barriers across all four stages of the process of seeking treatment for a mental disorder, there are many more barriers for Indigenous people at the stage of actually contacting a mental health service. This paper has also highlighted the key elements of successful partnerships and reiterates the need for more community and region-specific collaborative research to identify the mental health needs of local Indigenous communities. Rigorous ethically- and culturally-appropriate collaborative research could provide a sound basis for much-needed innovation to improve mental health services for Australia’s Indigenous population.

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