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Research studies on indigenous groups in Australia and internationally continue to illustrate the negative impact of colonialisation on their mental health (Radford, Harris et al. 1991; Blum, Harmon et al. 1992). Such studies have consistently shown that as the most economically, educationally, and socially disadvantaged members of society, indigenous individuals are also most likely to have the most severe and extensive mental health problems (Kahn, Henry et al. 1978).

Similarly, research within Australia has pointed to a rising prevalence of violent deaths in the form of homicide, suicide and parasuicide amongst indigenous Australians (Eastwell 1982; Reser 1989a). Rates of suicide in particular have risen from reported baselines close to zero two decades ago to a rate of approximately 30.7 per 100 000 (Suicide Research and Prevention Program, 1992). Even more concerning is that there has also been an escalation in accounts of depression (Kahn et al, 1978), self-mutilation (Hunter 1990), parasuicide (McKillop 1992), anxiety (McKendrick, Cutter et al. 1992), psychoses (Swan and Raphael 1995), interpersonal violence, alcoholism and low self-esteem (Hunter 1988a).

Despite this, perhaps the most comprehensive national consultancy report on Aboriginal mental health entitled "Ways Forward" argued that mental health has only recently been acknowledged as a significant health issue for indigenous people (Swan & Raphael, 1995).

Given the existence of such perspectives, it is not surprising that there is a scarcity of information within the literature regarding the nature and extent of psychological disorders within Aboriginal populations. It is also clear that the information, which does exist, is replete with methodological inadequacies and questions have therefore been raised regarding the validity of reported prevalence rates (Morice 1979).

The implications of this for Aboriginal Australians are enormous. Firstly, equity in access to services is severely compromised through the existence of mental health services that are essentially developed by mainstream service providers for 'mainstream' or westernised service users. Secondly, serious consideration of methodologically and culturally valid methods of intervention at primary, secondary and tertiary levels has failed to be realised within the literature and within clinical practice. The result is that we now have a situation in which the reported prevalence rates of mental health in Aboriginal communities fails to equate with the level of therapeutic intervention that is clearly necessary within this population group (Hunter 1993).

This paper therefore argues for an approach to Aboriginal mental health, which incorporates a range of unique risk factors, implicated in the development of psychopathology for Aboriginal people. Whilst acknowledging that risk factors elucidated in the mainstream literature has some relevance for Aboriginal people, there also exists a range of fundamental social and environmental stressors, which affect indigenous people uniquely. It is these unique factors, which have created a heightened risk for the development of mental health problems amongst Aboriginal people. The primary focus of this uniqueness is the issue of culture. In my PhD research, I have explored the basis of misdiagnosis, or the demonstrated failure of mainstream mental health services to identify early signs of mental ill health amongst Aboriginal clientele. Whilst the issue of clinical acumen has been widely discussed as a primary factor, this explanation is problematic in that it has yet to be articulated or operationalised adequately. In line with this, my Phd has as it's main theory that culture is the primary factor which both triggers and maintains mental health problems in Aboriginal people. The argument is therefore that there is a clear onus upon the practitioner to be trained sufficiently to be able to explore and assess cultural issues as the basis of differential diagnosis: that is, when is something culture, and when is it a real mental health problem.

The need for such a unique approach has been considered in the context of evidence indicating a rise in the rate of mental ill health within Aboriginal populations and an

associated failure of the psychiatric and psychological literature to anticipate and address such a rise (McKendrick and Thorpe 1994).

In attempting to account for such a failure it will be argued that whilst the available literature has focused on identifying risk factors common to the existence of psychopathology, this focus has, historically failed to incorporate Aboriginal conceptualisations of mental health. The result is that, in the absence of explorations of cultural explanations for disorders, the valid diagnosis of mental health has often been compromised (Eastwell, 1982).

There is clearly a need for serious consideration of the mental health needs of Aboriginal youth, and particularly the (culturally) valid and reliable identification of those most at risk of developing mental health problems (Hunter 1988b). Clearly, there is a need to explore the feasibility of providing a culturally and scientifically valid means of identifying mental health problems in Aboriginal youth. Such culturally appropriate identification is seen as a pivotal first step towards the future provision of research, which is able to contribute to a better (and more valid) understanding of Aboriginal mental health

In line with this, my PhD has developed a psychological measure, *the Westerman Aboriginal Symptom Checklist – Youth, (Westerman 2003)* that can be used to identify early risk in a target population of Aboriginal youth aged between 13 – 17 years. It has focused upon identification of depression, anxiety, suicidal behaviours and self-esteem problems and has screened 203 young people in the Northwest of Western Australia and throughout Perth.

In addition to this, the research has also developed a *Model of Cultural Validation of Mental Health Problems for* the assessment of mental health problems amongst Aboriginal people. The purpose of this model is to provide clinicians with a process, which ensures that diagnosis incorporates cultural factors, which have been demonstrated to impact upon on the validity of client assessments. Whilst the focus of the model is on

diagnosis, the framework will also aid clinicians to assess the extent to which cultural factors are also able to contribute to any bias within the client-clinician therapeutic relationship. The model therefore incorporates all of the stages of the therapeutic exchange from establishing rapport or engagement, to assessment, and termination.

Further solutions include the appropriate use of cultural consultants and, finally, proposing a *Scale of Acculturation,* for working with Aboriginal clients. The Acculturation Scale has been proposed as a solution to the issue of cultural heterogeneity, and provides a guide for the clinician on how best to assess the relevance of the Aboriginal worldview for clients.

In summary, whilst the research will hopefully provide clinicians, with a 'tool kit' to use in assessment of mental health issues with Aboriginal clients, the most important outcome will be the provision of clear guidelines for more appropriate clinical practice. Currently, there is awareness that work with Aboriginal people is different: the trouble is that these differences have never really been clearly articulated, or translated in such a way that the average clinician is able to incorporate these factors within their day to day practice. Hopefully, we are slowly heading in that most important direction.

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