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Country revealing the way: evaluating Elder-governed cultural therapy for Aboriginal and Torres Strait Islander young people with mental health conditions

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The known: Aboriginal and Torres Strait Islander young people have poorer mental health outcomes than their non-Indigenous same-age peers and do not gain the benefit they need from Western mental health care.

The new: An Elder-governed cultural therapy program was developed, delivered and found to be effective for improving the social and emotional wellbeing of young Indigenous participants aged 7–18 years.

The implications: Cultural therapy may be an effective intervention for Aboriginal and Torres Strait Islander young people with mental health conditions and should be offered alongside but separate from Western mental health management.

Abstract

Objectives: To assess the effectiveness of an Elder-governed cultural therapy program for Aboriginal and Torres Strait Islander young people with mental health conditions.

Study design: A cultural therapy program for Aboriginal and Torres Strait Islander young people was designed, delivered and qualitatively evaluated.

Setting: The cultural therapy was conducted in two locations: Royal Park, a traditional camping area for members of the Kulin Nation adjacent to the Royal Children's Hospital Melbourne; and a psychology and animal-assisted therapy practice located on a rural property 50 km north-west of Melbourne.

Participants: Twenty Aboriginal and Torres Strait Islander young people aged 7–18 years with mental health conditions completed the cultural therapy program between October 2021 and April 2024.

Main outcome measures: Yarns were conducted with the young people, their parent or carer and the cultural therapist before, immediately after and 3 months following completion of the therapy. In addition, fieldnotes and photographs were used to record the sessions. Effectiveness of the cultural therapy was assessed based on participation and engagement of the young person in the cultural therapy; their social and emotional wellbeing over the course of the cultural therapy; and their social and emotional wellbeing 3 months after completion of the cultural therapy.

Results: All participants willingly attended and actively engaged in the cultural therapy. Social and emotional wellbeing of participants improved over the course of the cultural therapy, and 3-month follow-up sessions revealed these improvements to be lasting. Centring Aboriginal ways of knowing, doing and being and actively engaging Country as a co-therapist were key to the effectiveness of the therapy.

Conclusion: The cultural therapy was found to be beneficial for Aboriginal and Torres Strait Islander young people with mental health conditions and should be offered alongside but separate from Western mental health management.

Aboriginal and Torres Strait Islander young people have more dire mental health outcomes than their age- and gender-matched non-Aboriginal and Torres Strait Islander peers.[1] In particular, a much higher percentage report high or very high levels of psychological distress (33% versus 13%) and/or a long term mental health condition (29% versus 16%).[2] In addition, mental illness independently contributes to worsening physical health status and premature death, and these effects are potentially transgenerational.[3]

Within contemporary settler colonial Australian society, Aboriginal and Torres Strait Islander people are marginalised — economically, socially and politically.[4] As a result of the many and varied processes of colonisation, many Aboriginal and Torres Strait Islander people are also disconnected from Country, including Ancestors, Totems and Creation Stories, as well as their attendant life-sustaining cultural practices.[5-9] Country here is understood as the natural environment and is inclusive of the land, skies and waterways of a particular area, as well as the animals and plants they support, and the wind, rain and numinous forces that animate Country.[10] Disconnection from one's Country, one's kin and one's culture is known to be associated with increased rates of mental disorders among Aboriginal and Torres Strait Islander people.[11,12] Within an Aboriginal and Torres Strait Islander worldview, physical and mental health cannot be separated from spiritual health and wellbeing.[8,13] Indeed, spirituality is considered central for health and wellbeing by Indigenous peoples around the globe.[14] Health and wellbeing are made manifest through reciprocal relationships of care with the earth and its complex environmental ecosystems.[15] Within a Western framework, mental health is considered separate from physical and spiritual health domains.[16] Aboriginal and Torres Strait Islander epistemologies, ontologies and axiologies of health and wellbeing are consequently considered secondary to Western health models of care within Western health care systems, and are ignored or excluded if there are perceived conflicts.[17,18]

Nevertheless, cultural revitalisation approaches, in Australia and overseas, often linked with decolonising practices, continue to enable the health and wellbeing of Aboriginal and Torres Strait Islander, Māori, First Nations Canadian and Native American Indian young peoples.[19] Researchers in Australia, for example, have proposed strengths-based spiritual healing practices, self-determined by Aboriginal and Torres Strait Islander peoples to counter "white patriarchal ethnocentric norms".[20] Wen-Shing Tseng, an emeritus professor of psychiatry at the University of Hawaii, has emphasised the importance of considering culture in clinical formulation and management planning processes.[21] He articulates that culture may influence the formation of mental disorder, give rise to coping styles to deal with stress linked with mental disorder, modify the clinical presentation of mental disorder, affect the severity and frequency of mental disorder, and shape its management.[21]

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Yet, how to include culture in the Western mental health service system is much debated. Researchers in the United States have cautioned against embedding Native American Indian cultural knowledge and practices because of the ongoing harmful colonisation processes active in these service delivery systems.[22] Researchers working across Canada, Australia and New Zealand suggest that culturally supported Indigenous practices can be offered alongside but separate from Western mental health management.[23] The feasibility of offering cultural practices in a culturally appropriate way for Aboriginal and Torres Strait Islander young people is drawn into sharp focus because most now live in urban centres with mental health care delivered via hospital inpatient and outpatient services that are often seen as alienating and distressing places.[24] The question of how research into First Nations mental health should be conducted is similarly vexed; hence, an innovative research method involving First Nations researchers and participants at every stage was developed and adopted for this project.

Methods

This study forms the second stage of a research project in a program grant led by an Aboriginal doctor and epidemiologist (SE, Noongar). It involved development, delivery and evaluation of an Elder-governed cultural therapy program by an Aboriginal child and adolescent psychiatrist (AV, Wathaurung) and an Aboriginal senior clinical psychologist (JW, Wamba Wamba, Wadi Wadi).[25] The approach was informed by findings from the first stage of the research project, which involved yarning with 44 Victorian Aboriginal and Torres Strait Islander Elders and others involved in community health and wellbeing roles relating to the relationship of culture to health.[26] The team was guided in the establishment phase by an advisory group of First Nations health care professionals and is governed by a board of Elders, one of whom is author Uncle HP (Gunai). A First Nations research assistant was engaged on the project during the data collection and analysis of stage 1, and another during stage 2 to obtain consent from participants, attend the cultural therapy sessions to support participants, and document the process. JM, a non-Indigenous cultural geographer and architect, who is married to AV, co-led the project, developed the research methods, and was part of the collaborative team that conducted the analysis and collaborated on writing this article. NT, a non-Indigenous sociologist, was involved during stage 2, along with the First Nations research assistant, in gathering data through pre-therapy and post-therapy yarns. NT was also part of the collaborative team that conducted the analysis and collaborated on writing this article. Twenty participants completed the project. Four participants left the study: the first two participants who had consented to participate in the study did not attend any cultural therapy sessions, one withdrew after several sessions because she said she "felt better", and the fourth was forced to withdraw because of a complex breakdown in out-of-home care arrangements.

Multiple perspectives were built into the analysis by drawing on the perspectives of four participants — the young person, their family member or caregiver, the cultural therapist, and a research assistant — at three time points: before therapy commenced, immediately after the last session was completed, and 3 months later. Data were collected via the Indigenist research method of yarning rather than through semi-structured or structured interviewing. As described by researchers Dawn Bessarab and Bridget Ng'andu,[27] yarning is intrinsically relational, moving freely between the research prompts, social chitchat, personal self-reflection and storytelling. Participants openly shared aspects of their lived experience as they considered whether and how cultural therapy was beneficial to them, or the young person they supported. They also reflected on the material practices and encounters with the more-than-human world during the cultural therapy: message sticks, sand drawings, animals they tended, stones and leaves they collected, or insects and birds they followed. These often prompted memories of events and relationships that had been important during therapy.

While yarns are typically free flowing and circular, the research assistant scaffolded them with some broad open-ended questions. These varied depending on whom the yarn was with and the stage of the study (before, immediately after or 3 months following completion of the therapy), but were along the lines of:

- What do you know about your cultural heritage?
- What sort of things do you do at home or in your life that you consider cultural?
- What do you remember about the cultural therapy sessions?
- Which things did you enjoy doing most and least during the sessions?
- How did you feel while doing cultural therapy?
- What has changed in your life since commencing the cultural therapy?
- What is one thing you would change about the cultural therapy?

Data for the research also included photographs taken during the therapy sessions and fieldnotes recorded by the research assistant. These data enabled all members of the team of analysts to better understand the trajectory of the cultural therapy and its effect on the participants. Yarns conducted with older, more verbal parents and guardians tended to yield richer data than those conducted with the young people, some of whom were very young and some of whom were not very verbal. Photographs and descriptions by the research assistant captured demeanour, body language, facial expressions, degree of interest and engagement, as well as the changing provisions of Country — the weather, the seasons, the birds, insects and plants — which shaped each session.

Analysis adhered to the protocols of constructivist grounded theory and community-based participatory action research, both of which have been effectively combined by other researchers.[28-30] Constructivist grounded theory is underpinned by symbolic interactionism.[31] To mitigate the effects of social, cultural, educational and disciplinary bias, a team of four analysts (AV, JM, JW and NT) independently read the yarn transcripts and reviewed the descriptive and photographic records of each session before inductively coding, writing memos, and identifying provisional themes. The team had varying degrees of insider or outsider status to the cultural therapy and to the Aboriginal community and participant or observer status to the cultural therapy. This multiperspectival approach was developed to make the blind spots that arose from the intrinsic interests and disciplinary training of each coder apparent.

Analysis started immediately. The approach was inductive, with theory arising from the interpretation and analysis of the data itself through self-reflexivity. The team met via videoconferencing to discuss their provisional themes over four sessions, taking it in turn to begin. Rather than struggle to reach

agreement, differences were also findings.[28] Theory was formed through the development of a plausible relationship among concepts. It is constructivist and interpretivist in nature, focusing on meaning and interpretation — that is, people's understanding and construction of their reality. This is in line with Indigenist research methods that hold to a relational worldview in which people and Country are indivisible and always in a process of becoming.[32] Due to word constraints, this article focuses on the four dominant, agreed themes. Data collection concluded when the study reached theoretical saturation — the point at which findings became repetitive and no new knowledge was emerging.

Study design

Researchers developed and qualitatively evaluated an adjuvant, culture-centred model of therapy for Aboriginal and Torres Strait Islander young people with mental health conditions. The cultural therapy program, delivered on Country between 11 October 2021 and 26 April 2024, privileges Aboriginal and Torres Strait Islander ways of knowing, being and doing.[25] Two of us, who are Aboriginal mental health professionals, hereafter referred to as cultural therapists, delivered the program: AV, a consultant child and adolescent psychiatrist and the project lead (Wathaurung); and JW, a senior clinical psychologist (Wamba Wamba, Wadi Wadi). The cultural therapists did not review clinical case files before conducting the therapy, nor did they follow a typical Western therapeutic approach. Instead, they invited participants to explore with them place-based cultural practices that took a variety of forms: walking in Country, art, music, dance, or animal-assisted therapy. Each young person received about 8 hours of cultural therapy over 6–8 sessions. An Aboriginal research assistant obtained consent for participation from each young person, participated in each session, and provided ongoing support to the participants and their families.

The cultural therapy was particular to the therapist and participants; however, its form is generalisable. Its hallmarks are reflective, narrative and dynamic interpersonal processes, mutual co-learning built on respect between the participant and therapist, and respect for Country. Informed by Western psychiatric supportive psychotherapy and cognitive behavioural therapy, cultural therapy is iterative, fostering internalisation of coping styles and interpersonal skills in young people. However, the specific practices varied, reflecting the different perspectives, skills and priorities of each therapist. A crucial element of the cultural therapy was an invitation to the young person and their guardian, and in some cases extended family, to participate in a cultural practice that is integral to the therapist's own life, so that the practice was an authentic and congruent expression of lived epistemologies and ontologies.

The cultural therapist, research assistant, young person and their guardian engaged in cultural therapy together as an antihierarchical, relational community of Aboriginal and Torres Strait Islander people within a broader environment of other-than-human entities. All remained expectant of revelations from Country, community and the spirit world regarding how to live connected and fulsome lives. Each person — therapist, young person and guardian alike — then shared what they discerned, reflected on the revelations together, and from them made meaning. At the conclusion of the cultural therapy, agreed themes particular for each young person were inscribed with a wood burner on a message stick — a piece of carefully chosen wood, stripped of its bark and smoked following cultural protocols. This message stick was gifted to the young person as a tangible reminder of their cultural connections and all they learned in the cultural therapy.[26]

Data collection

Data for the research were collected via three methods: participant observation, photography, and the Indigenist research method of yarning. Yarning is a culturally specific method of data collection that involves a non-hierarchical, circular, multilayered style of conversation.[27] It aims to build community rather than merely extract knowledge for the benefit of researchers.[33,34] Yarning also provides greater potential for co-constructed meaning and understanding to emerge in dialogue, as opposed to the researchers' analytical frame being imposed from the outside or above (as it might be in a structured interview process, for example).[35] Yarns were conducted with each young person and their parent(s) or carer(s) before, immediately after and 3 months following completion of the cultural therapy program. Yarns were also conducted with the cultural therapist once each participant completed the cultural therapy program.

Photographs and detailed notes of what was said and done during each session, and by whom, were recorded by the research assistant who accompanied the young person, their parent(s) or carer(s) and the cultural therapist during each therapy session.

All participants provided written and oral consent to participate in the research. Data from participants who later withdrew from the research were not included in the study. All data were de-identified and stored in a password-protected folder on a secure university server.

Data analysis

An innovative hybrid qualitative method of community-based participatory action research and constructivist grounded theory was developed for the research project.[28] Given the historical complicity of traditional Western research methods — both quantitative and qualitative — with dispossession and colonisation, community-based participatory action research is a method preferred by Indigenous communities.[36] It is informed by Indigenism, a critical theory that privileges Indigenous ways of knowing, being and doing, with community members involved at all levels of the research, from governance through to analysis.[32,37] Constructivist grounded theory is a widely recognised, rigorous method for undertaking thematic analysis[31] that has been effectively used in conjunction with community-based participatory action research by other First Nations researchers.[29,30] It involves coding, memo writing, and provisional theme finding in a range of data — yarns, photographs, fieldnotes — by a multiperspectival team to minimise bias.[28] The Appendix and a previously published methods article[28] provide further details.

Setting

The cultural therapy was conducted in two different locations: Royal Park, a traditional camping area for members of the Kulin Nation adjacent to the Royal Children's Hospital Melbourne; and a psychology and animal-assisted therapy practice located on a rural property 50 km north-west of Melbourne. The therapy sessions were held between 11 October 2021 and 26 April 2024.

Participants

Aboriginal and Torres Strait Islander young people aged between 7 years and 18 years who had multiple Western mental health

diagnoses, including autism spectrum disorder, attention deficit hyperactivity disorder, anxiety, depression and post-traumatic stress disorder, were eligible to participate. They were recruited from an urban hospital outpatient setting to which they had been referred for mental health management via Aboriginal Health Liaison Officers.

Reporting

We used the TIDieR (Template for Intervention Description and Replication) checklist[38] to describe the intervention, the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist[39] to ensure ethical publishing and reporting of our study, and the CONSIDER (Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous People) statement to ensure cultural safety in our reporting[40] (Supporting Information).

Ethics

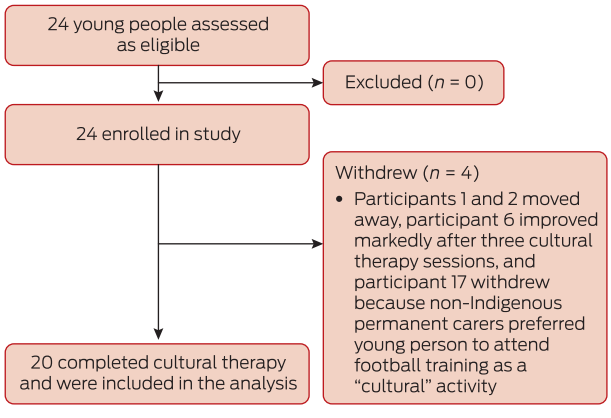
A board of Elders and Senior people provided governance, and an advisory group of Aboriginal and Torres Strait Islander health professionals provided guidance for the project. The project was approved by the Royal Children's Hospital Melbourne Human Research Ethics Committee (2019.207/56941). The participants constituted a vulnerable group, so cultural therapy was undertaken with either a consultant child and adolescent psychiatrist (AV) or a senior clinical psychologist (JW) present to monitor safety during the study.

Results

Twenty-four Aboriginal and Torres Strait Islander young people were recruited for participation, of whom 20 (15 male and 5 female) completed the cultural therapy; further details of the participants are provided in Box 1 and Box 2. Many participants were disconnected from culture and two were experiencing psychoses. A few participants came from families with strong histories of involvement in community and culture, but not all had spent time passing it on to their children through busyness, lack of confidence, a history of trauma or subsequent disconnection due to relocation.

Most young people participated in the therapy with their primary caregiver (parent or guardian). The caregivers were also participants in the research, as were the cultural therapists, since both provided data via yarning about the experience and effect of the cultural therapy on the young person who was the primary participant. Seven young people were living in out-of-home care with non-Indigenous carer(s), who were the participating caregivers. Three young people were living with a non-Indigenous parent, who was the participating caregiver. The final ten young people were living with at least one Indigenous parent, who was the participating caregiver. No adverse outcomes of the cultural therapy were reported.

1 Participant flow diagram



Multiperspectival grounded theory analysis of the qualitative research data revealed four main findings about whether and why the cultural therapy program was effective. Firstly, all twenty young people who completed the program with their caregivers eagerly attended and actively participated in the therapy sessions. This was significant given the struggles many were experiencing in participating in the activities of daily life and failures to engage in other types of therapy. Secondly, all young participants also experienced considerable improvement in their social and emotional wellbeing during the individual therapy sessions as well as over the course of the therapy. Three months following completion of the therapy, these changes were found to be lasting. Thirdly, the centring of Aboriginal and Torres Strait Islander ways of knowing, being and doing was found to be key to the effectiveness of the cultural therapy. Finally, Country's role as co-therapist was also found to be critical to the effectiveness of the cultural therapy. These findings are discussed below.

All participants eagerly attended and actively engaged with the cultural therapy

Attendance was a significant measure given that all participants had struggled to engage with Western mental health therapies and most were taking medication to treat their various symptoms and/or conditions but found these to have limited benefit. All participants were also struggling to participate in the activities of daily life, at school and/or home. With the cultural therapy, however, not only did participants engage, but they willingly attended all sessions and reported that they loved the program. The one finding in post-therapy yarns common to all was that they wished the program could continue.

> He has never been able to cope with anything else and he has tried all different types of counselling. [But with cultural therapy, after] two sessions I could already see a difference and he was happier and he was excited to do this whereas if you take him to the other ones it was a nightmare. [Here] it was watching someone working with him and he was actually acknowledging it and he was responding to it.
> — Three-month follow-up yarn with parent of 10-year-old participant

All participants experienced enhanced social and emotional wellbeing in response to the cultural therapy

All participants experienced considerable improvement in their social and emotional wellbeing in response to the cultural therapy. Participants, parents, carers and therapists observed physiological changes ("calmness", "felt lighter", "less tense"), better emotional regulation, increased resilience, a reduction in symptoms associated with attention deficit hyperactivity disorder (better attention, learning, recall and impulse control), and improvements in parent–child relationships. Improvements in social and emotional wellbeing were observed during each cultural therapy session and over the course of the 6–8 sessions,

2 Participant characteristics

Participant	Age (years)	Gender	Living with	Primary carer(s)	Diagnoses	Years since diagnosed	Past/present management	Comorbid conditions
1 (W)	11	Male	M+	Yes (M) [A,TSI]	2,5	5+	1e/1e	Generalised anxiety disorder
2 (W)	13	Male	M+	Yes (M) [A,TSI]	2,6	5+	1e/1e	
3	15	Male	M and F	Yes (M) [A]	1,4	5+	3e/3e	
4	10	Male	M	Yes (M) [A]	2,5	4	1e/1e	Social anxiety disorder
5	17	Male	M	Yes (M) [A]	4,7	5+	4e/4e	Social anxiety disorder
6 (W)	14	Female	PC	No	4	5+	3e/3e	
7	9	Male	M+	Yes (M) [A,TSI]	1,2	4	1ne/2e	
8	11	Male	M and MGM	No	1,2	5+	1e/1e	Social anxiety disorder
9	12	Male	PC	No	2,5	5+	1e/1e	
10	13	Female	MGF+	No	4,7	2	4e/4e	Panic disorder
11	7	Male	M+	Yes (M) [A]	2,5	2	1ne/2e	
12	10	Female	M+	No	1,2,5	5+	1e/1e	Separation anxiety disorder
13	11	Female	M	No	2,4,5	2	2e/2,3e	Generalised anxiety disorder
14	15	Male	PC	No	2,6	5+	1e/1e	
15	12	Female	M+	Yes (M) [A]	2,4	4	1ne/3e	
16	8	Male	PC	No	1,2,5	5+	1e/1e	Generalised anxiety disorder
17 (W)	14	Male	PC	No	2,5	5+	1e/1e	
18	10	Male	M and F	Yes (F) [A]	1,2	5+	1e/1e	Social anxiety disorder
19	9	Male	M and F	Yes (M) [A,TSI]	2,5	4	1e/1e	
20	8	Male	PC	No	2,5	4	1e/1e	
21	10	Male	RC	No	2,6	5+	1ne/2e	
22	11	Male	M+	Yes (M) [A]	1,2,5	5+	1e/1e	
23	15	Female	M and F	Yes (M) [A]	3,4	5+	3e/3e	Panic disorder
24	18	Male	MGM	No	1,2,4,5	5+	1e/1e	

Participant: W = withdrawn; participants 1 and 2 moved away, participant 6 improved markedly after three cultural therapy sessions, and participant 17 withdrew because non-Indigenous permanent carers preferred young person to attend football training as a "cultural" activity. **Living with:** F = biological father; M = biological mother; MGF = maternal grandfather; MGM = maternal grandmother; PC = permanent carer; RC = residential care; + = and partner. **Primary carer(s):** A = Aboriginal; F = father; M = mother; TSI = Torres Strait Islander. **Diagnoses:** 1 = autistic spectrum disorder; 2 = attention deficit hyperactivity disorder combined type; 3 = attention deficit hyperactivity disorder inattentive type; 4 = major depressive disorder; 5 = oppositional defiant disorder; 6 = conduct disorder; 7 = psychotic disorder. **Past/present management:** 1 = stimulant medication plus parent management training, social skills training, mood regulation training and anxiety management training; 2 = atomoxetine plus parent management training, social skills training, mood regulation training and anxiety management training; 3 = selective serotonin reuptake inhibitor plus cognitive behaviour therapy and interpersonal therapy; 4 = antipsychotic medication and mood stabilising medication plus cognitive behaviour therapy and interpersonal therapy; e = effective; ne = non-effective. ◆

and these extended beyond the cultural therapy sessions themselves. The young person was more likely to be attending school on a regular basis, for instance, and parents and carers were less likely to be receiving phone calls from the school about the young person's behaviour. Three-month follow-up yarns revealed that the effects of cultural therapy were lasting.

> As he engaged in the therapy, he became far more talkative, far more sharing about his life at home, his life with soccer, his life at school, always remembering what we talked about. So, for example, I'd asked him about the kangaroo grass and he would just immediately picture it and [demonstrate its shape] with his fingers … And I thought this boy is actually very switched on, and yet he's got technically an intellectual disability, he has all these troubles with Western schooling, but he's so different in the park and in the therapy.
>
> — Post-therapy yarn with cultural therapist following therapy with 14-year-old participant

Centring Aboriginal and Torres Strait Islander ways of knowing, being and doing was key to the effectiveness of the cultural therapy

Therapists did not review participants' Western health records before commencing cultural therapy. Instead, they began from the principles that Aboriginal and Torres Strait Islander worldviews are distinctive, vital to existence and involve situating oneself in relation to people, place and the custodians

of that place.[36] Consequently, the cultural therapy was conducted outdoors in Country; it was inclusive of parents, carers and other family members; it was antihierarchical (participants and therapists learned together from each other and from Country); and attributes that are often pathologised in Western diagnoses were reframed. Distraction by, and an intense and sustained interest in, a particular beetle or a bug, for instance, became an opportunity to watch, learn and wonder together. Participants, parents, carers and therapists all agreed that the cultural therapy's focus on connecting with and collectively learning about Country and culture was central to participants' active and willing engagement in the program and also its effectiveness.

> [I like this therapy] because he talks about the stuff that I want to know about and not the stuff that makes me sad.
> — Post-therapy yarn with 12-year-old participant

> I think this [therapy] is more better … It's easy to do and not complicated … Cos you get to go walking … [I learnt] about the plants and many other trees that I haven't known … And I got to make a boomerang.
> — Post-therapy yarn with 12-year-old participant

Country's active role as co-therapist was also critical to the effectiveness of the cultural therapy

Country was an active co-therapist in the cultural therapy, and this, too, was critical to its effectiveness. Country would provide different experiences every session. The participant or therapist might notice these things, follow them, and talk about what they might mean, what their traditional uses are, and what they teach about living relationally. Being in Country, walking in Country, learning about Country, connecting with each other and the other-than-human world were the primary foci of the therapy. All participants enjoyed connecting with Country and engaged well with the therapy for this reason. Connecting with Country was regulating for participants and is a practice they can readily integrate into their daily lives.

> [After the first session] he could pick differences between trees. One tree he would say 'that's a good tree' and 'that's a bad tree' and different vibes and things like that. He was walking [with his girlfriend] to the train station and it was supposed to be dead quiet and he pointed to the tree and said he felt like he was being watched and [then] he got this sudden feeling that everything is going to be okay.
> — Post-therapy yarn with carer of a 14-year-old participant

Discussion

This was a small qualitative research study of a therapy program devised and developed, under the guidance of Elders, by two Western-trained therapists with more than 20 years' experience working with young people with severe mental health conditions. In their Western practice, AV works therapeutically using a supportive psychodynamic psychotherapy approach while JW uses a cognitive behavioural therapy approach. For the cultural therapy, both drew on their Western training but primarily were engaged in connecting culturally. So a key question at the conclusion of the study is whether the effects are attributable to the therapeutic approach, or to the particular skills of the therapists conducting the study.

A precedent to consider is the Friendship Bench program, developed by Zimbabwean psychiatrist Dixon Chibanda to address the paucity of mental health professionals in the country. Grandmothers were trained to deliver cognitive behaviour-based problem-solving care sitting outside on a park bench with community members.[41] This program was found to significantly improve the mental health and coping mechanisms of depressed participants over six sessions.[41] In the past, grandmothers were the cultural healers for such conditions before Westernisation and urbanisation in Zimbabwe.[41] Decentring health through a community-based model led by Elders shares similarities with cultural therapy. It has been shown to be transferrable: Friendship Benches have now been established in New York and Washington in the United States to reduce social isolation.[41]

With increasing numbers of Aboriginal and Torres Strait Islander counsellors being trained, a potential cultural therapy workforce is emerging.[42] These health professionals could work alongside primary care providers such as general practitioners as well as specialist mental health services. Given colonisation's tendency to distort, control and/or weaken Aboriginal and Torres Strait Islander cultural expression,[43] and that of similar communities overseas,[22] many authors have argued for traditional cultural practices occurring separate from Western mental health care.[23] Indeed, our board of Elders strongly advised and advocated for this when the cultural therapy program was being established.

Since completion of the project, AV and JW have established a culture-centred and animal-assisted mental health program on an acreage in outer Melbourne. About twenty Aboriginal and Torres Strait Islander young people, including some participants, continue to receive ongoing care with their family members, along with new clients referred by the Victorian Aboriginal Community Controlled Health Organisation. Two of us (SE and AV) have been awarded grant funding to develop and test a training manual to see how effectively skills can be transferred to other Aboriginal and Torres Strait Islander health professionals.

Future research studies should also include a randomised controlled trial of cultural therapy utilising yarning as a culturally appropriate means of assessing health and wellbeing outcomes. In addition, future systematic investigation of particular mental health conditions such as autism spectrum disorder, attention deficit hyperactivity disorder, anxiety, depression and psychotic disorders, and any differential benefits that cultural therapy may offer, is needed. Furthermore, the potential benefits of therapists delivering cultural therapy alongside other therapies should be examined.

Limitations

While the qualitative methods used in this study are rigorous and have led to a rich, multiperspectival dataset, effectiveness and generalisability would be best demonstrated through operationalised outcome measures[44] and a randomised controlled design.

Conclusion

A cultural therapy program was designed, delivered and qualitatively evaluated for Aboriginal and Torres Strait Islander young people with mental health conditions. Every young person who completed the therapy engaged well and attended willingly, even though they had past histories of not attending

and not engaging in hospital-based Western mental health care. Participants' social and emotional wellbeing improved over the course of the cultural therapy, and 3-month follow-up sessions revealed these improvements to be lasting. Centring Aboriginal and Torres Strait Islander ways of knowing, doing and being and actively engaging Country as a co-therapist were crucial to the effectiveness of the therapy. In future, cultural therapy should be offered to Aboriginal and Torres Strait Islander young people with mental health conditions alongside but separate from Western mental health management.

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Supporting Information

Additional Supporting Information is included with the online version of this article.