

Towards an Aboriginal Knowledge Place: Cultural Practices as a Pathway to Wellness in the Context of a Tertiary Hospital

Abstract

The Indigenous community in Australia is beset by extraordinary disadvantage, with health outcomes that are substantially worse than those of non-Indigenous citizens. This issue has consequently been the subject of voluminous health research that has given rise to a range of affirmative action policies progressively implemented over the past decade. Statistics, however, remain dire. This paper argues that new models of research practice and policy are required that are inclusive of Indigenous ways of knowing, doing, and being. It proposes a new framework to promote wellness in urban hospitals for Aboriginal young people and their families modelled on equal, 2-way dialogue between Western and Indigenous ways of doing health. Cultural safety is an essential starting point, but a range of other practices is proposed including oversight by a board of Elders, inclusion of traditional healers in treatment teams, and “space, place, and base” within the hospital building and its grounds so that it can be used as a site for culturally engaged Indigenous outpatient care. Practice approaches that embed culture into assessment, formulation, and treatment are being trialled by the authors of this paper, three of whom have Aboriginal heritage. Together the authors are working toward building an Aboriginal Knowledge Place within the major teaching hospital where they work.

Keywords

Aboriginal people, Australia, health care, transcultural, place, nomothetic, ideographic, Indigenist

Glossary

Aunty and Uncle: titles of respect for women and men who are considered to carry significant knowledge and wisdom.

Country: tribal lands, inclusive of waterways, plants, animals, rocks, and celestial bodies. To be “on Country” or “off Country” indicates whether someone is physically present on or distant from their tribal lands.

Deep listening: quiet, contemplative, listening with a spiritual dimension.

Story: significant narrative emerging from an Indigenous ontology (Langton, 2002).

Welcome to Country: a ritual that is considered important for cultural safety within Aboriginal culture. It is offered by a “Traditional Owner” (someone with tribal connections to Country) to all visitors to protect them from the emplaced ancestral spirits who dwell in the land and waterways.

Yarning: a word that describes conversation that is inclusive of “deep listening.”

Authors

Alasdair Vance, matrilineal heritage Mt Emu people, Kulin Nation; MD, head of Developmental Neuropsychiatry Program, Royal Children's Hospital, University of Melbourne, Australia. Alasdair Vance is a child and adolescent psychiatrist. Joint lead author; involved in all aspects of article development. Contact: DNP Royal Children's Hospital, 50 Flemington Rd, Parkville, Victoria, AU, 3052 61 3 9345 4666; Phone: 61 3 9345 6002; Email: avance@unimelb.edu.au

Janet McGaw; PhD, senior lecturer, Faculty of Architecture, Building and Planning, University of Melbourne. Janet McGaw's expertise is in Indigenous place-making practices and collaborative, creative research with Indigenous communities. Joint lead author; involved in all aspects of article development.

Jo Winther, patrilineal heritage Mutti Mutti people, Murray River tribes; MAppSci, senior clinical psychologist, Developmental Neuropsychiatry Program, Royal Children's Hospital, University of Melbourne. Involved in developing Aboriginal Knowledge Place and this article.

Moira Rayner, matrilineal heritage Bundjalung/Yaegl people, Northern New South Wales coast; head of Koori Mental Health, Royal Children's Hospital, University of Melbourne. Involved in developing Aboriginal Knowledge Place and this article.

Acknowledgements

The authors would like to thank Selena White, head of Wadja Aboriginal Family Place, Royal Children's Hospital, for her advice and support for this article. We would also like to thank the following Victorian Traditional Owner Elders for their advice, support, counsel, and feedback for this article: Uncle Herb Patton, Auntie Bunta Patton, Auntie Ester Kirby, Auntie Rochelle Patton, and Garry Murray. An Australian Research Council Linkage Grant (J. McGaw: LP100100805) supported this work.

Introduction

Despite a range of policies implemented to address Indigenous health disadvantage in Australia (Anderson et al., 2006), Indigenous health outcomes remain dire. This paper will argue that the policies are fundamentally limited because approaches emerge from Western epistemologies that are wholly different from Indigenous "ways of knowing, being, and doing" (Martin & Mirraboopa, 2003). Indigenism, a new field of research that has emerged over the past 10 to 15 years to critique the dominance of Western epistemologies within the academy, has recently been employed as a methodology within health research and regional, community-based health care, but has not yet filtered into policy and practices in mainstream city hospitals. Urban hospitals remain alienating and undesirable paths to wellness, but they are often unavoidable as they are the only place for treatment for many complex health challenges. The authors, three of

whom have Indigenous heritage, work within a child mental health service in the state of Victoria, Australia.

This paper will describe the process these authors are undertaking to develop a model for an Aboriginal Knowledge Place in which Indigenism is enlisted to holistically augment Western biopsychosocial treatments, especially when Western medicine alone has failed. Improving cultural safety is an essential starting point, but a range of other practices is proposed: transformations to spaces within the hospital building and grounds so that they can be used for culturally engaged Indigenous outpatient care; trial practice approaches that embed culture into assessment, formulation, and treatment; traditional healers in treatment teams; and increased social and political agency through supervision and oversight by a board of Elders. The paper contextualizes the concept with an overview of progress to date and concludes by suggesting how the outcomes of full implementation of such a model could inform broader changes within communities and the health system.

Background

Research Methodologies and Policies for Indigenous Health Care in Australia

Broadly speaking, the literature that has informed Indigenous health care policy documents can be readily classified using the nomothetic and ideographic framework that emerged from the personality research field in the 1950s (Beck, 1953). Nomothetic research examines phenomena that can be objectively defined using psychometrically valid and reliable measures. Diagnostic groups can be characterized by phenomena that are believed to be generalizable across social and cultural contexts. In contrast, ideographic research explores numina that have an inherent significance, force, and power, defined subjectively by individuals. These numinous aspects are considered unique for each individual as defined by and for themselves. Both nomothetic and ideographic approaches are considered essential for good clinical practice (Bloch, 1997). For instance, biopsychosocial risk and resilience factors arising from nomothetic inquiry may be informed by ideographically defined coping styles, belief systems, and illness and wellness behavioural styles. Together these types of knowledge affect understanding of diagnoses, clinical formulations, and treatment plans that in turn influence engagement and adherence to medication and/or psychosocial treatments prescribed and the subsequent health outcomes achieved.

To date, the majority of research focused on Indigenous health in Australia has been nomothetic with some illustrative ideographic case histories/case examples to emphasize key themes. They include quantitative research targeting demographic risk factors (Australian Bureau of Statistics, 2010) and environmental risk factors (Clough et al., 2004; Dingwall & Cairney, 2011; Gault, Krupinski, & Stoller, 1970; Lee et al., 2009; McKendrick et al., 1990) as well as qualitative research focused on social risk factors (Bostock, 1924; Cawte, 1963, 1988; Eley et al., 2007; Hunter, 1991; Petchkovsky & San Roque, 2002) and clinical practice (Hunter, 1993, 2004; Peeters & Kelly, 1999; Turale, 1994; Ypinazar, Margolis, Haswell-Elkins, & Tsey,

2007). These studies have in turn informed important policy documents that have sought to frame a national response to the plight of Australia's First Peoples across health, education, and welfare sectors (Baxendell, 1997; Council of Australian Governments, 2008; Dudgeon, Milroy, & Walker, 2014; Dwyer et al., 2011; Eckermann, Dowd, & Chong, 2006; Edwards & Madden, 2001; Human Rights and Equal Opportunity Commission, 1997; Swan & Raphael, 1995).

The national apology to Aboriginal and Torres Strait Islander people (Australian Government, 2008) provided impetus and direction for a politically bipartisan, national and state government initiative termed "Closing the Gap in Indigenous Disadvantage." Key aims were to increase life expectancy, decrease child mortality, and improve educational and employment outcomes for Australian First Peoples. The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (Council of Australian Governments, 2008) outlined a program of reform focused on the first two aims with five broad priority areas identified. The *Close the Gap Progress and Priorities Report* (Holland, 2014) makes some compelling points about the work done to date. Specifically, it outlines the importance of developing a dedicated mental health plan and alcohol and other drug strategy for Aboriginal and Torres Strait Islander Peoples. It also emphasizes the need for an integrated approach to health issues and their social and cultural determinants, including the impacts of intergenerational trauma. Further, it associates this broad and integrated health strategy with the future development of a Closing the Gap program to decrease rates of incarceration, crime victimization, and out-of-home care. In 2010, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* was published (Purdie, Dudgeon, & Walker, 2010), and is now in its second edition (Dudgeon et al., 2014), with funding from the 2006 Council of Australian Governments Mental Health Initiative.

All of these policy documents are based on quantitative research and have included extensive ideographic case history narratives to inform key action principles, targeted aims, and models for clinical practice. Each advocates for a holistic model of care, culturally appropriate therapies, and genuine dialogue and partnership between Indigenous and non-Indigenous systems of health care.

Although the ideographic is typically positioned as a culturally inclusive approach, we argue that both nomothetic *and* ideographic research emerge from within a contemporary Western academic paradigm that has arisen from the Enlightenment, a period in the 17th and 18th centuries when reason and analysis emerged as the dominant epistemologies (Bristow, 2011) and individualism framed its cultural mores (Habermas, 1989). The same forces drove global exploration and colonization of Indigenous cultures during that era. Nomothetic research places emphasis on reasoned, objective, quantitative method, while ideographic research emphasizes the individual experience. In contrast, Indigenous epistemologies and cultural mores arise from different forces altogether. Kinship systems and a concept of "reciprocal belonging" (McGaw & Pieris, 2015, pp. 73-74) to *Country* (see Glossary) situate the individual within a network of human, ancestral, geological, and totem relationships that this paper will argue are equally important to health. These values and beliefs are not quantifiable, not measurable, and

not individually defined.

New Modes of Research Emerging from the Indigenist Critique

A growing number of Indigenous academics around the world have begun to critically reappraise the Western framing of their research fields (Garrouette, 2005; Lavallée, 2009; Martin & Mirraboopa, 2003; Rigney, 1999; Smith, 1999; West, Stewart, Foster, & Usher, 2013; Wilson, 2009). The term *Indigenism* has been coined to describe such an approach, drawing associations with other critical, liberation epistemologies (for example, feminism, poststructuralism, post-colonialism). Indigenist research aims to critique the Western research paradigm and provide an alternative discourse that centralizes Indigenous ways of knowing and being. Indigenist research requires Indigenous people to conduct research according to the following principles, enunciated by Martin & Mirraboopa (2003): Each people's worldview is distinctive and vital for their existence and survival; each people's collective social mores must be honoured as essential processes through which they live, learn, and situate themselves; each people's contexts are acknowledged as key shapers of their interpretation of past, present, and future experiences; and each people's voice, experience, and life and their lands are privileged. As the great Lakota chief Ota Kte (Luther Standing Bear) wrote:

The spiritual health and existence of the Indian is maintained by story, magic, ritual, dance, symbolism, oratory (or council), design, handicraft and folk-story. To check or thwart this expression is to bring about spiritual decline (Standing Bear, 1933, p. 255).

Indigenist academics strive to add to the knowledge acquired via the Western research paradigm so that policy, practice, and evaluation may be more socially and culturally informed with respect to Indigenous Peoples. Rigney (1999) emphasises the need to liberate Australian Indigenous knowledge from the control, storage, and extraction techniques inherent in the Western academic discourse. Smith (1999) argues as a "colonised" Maori woman that Western research and knowledge paradigms need to be decolonised so that research can cease being "one of the dirtiest words in the Indigenous world's vocabulary" (p. 1). Garrouette (2005) calls for the Western academy to embrace an American Indian "radical Indigenism" that involves wholly new models of inquiry, especially the meaning and utility of the "subjective" and different constructs of the "observable" along with "unique (non-repeatable) events" (p. 170). Lavallée (2009) outlines how the epistemological and ontological basis of research affects a project, determining what is considered worthy of study, what and how research questions are asked, and what approach is taken to analysing and interpreting data. She asserts that Indigenist researchers should frame all these aspects of a project from the standpoint and foundation of their culture (Algonquin, Cree, and French Métis for Lavallée).

The philosophy of science has aided the development of the Indigenist discourse, establishing the epistemological and ontological basis for Indigenist research from which methodologies flow. However, the health field has been slower to embrace what are perceived to

be non-evidence-based approaches despite the obvious failures of Western lifestyles, medicine, and health care to deliver wellness to Aboriginal and Torres Strait Islanders in Australia. Cunningham and Stanley (2003) signalled the urgency of rethinking health from an Indigenous worldview, but to date relatively few research publications have done this. Exceptions include a posthumous Indigenist paper by Joe Roe (Purungu), a Karrajarrri/Yawru man on Ngarlu (a cultural and spiritual strengthening model; Purdie et al., 2010) and Hovey, Delormier, & McComber's (2014) research into diabetes prevention that argues for a social-relational perspective inclusive of a spiritual realm.

There is, however, an emerging practice-based literature that advocates for embedding Indigenous ways of knowing, doing, and being in primary health care delivered in communities and brokered by Aboriginal health care workers. Western models for health continue to drive care, but there are signs of greater equality in the two-way communication between Western and Indigenous paradigms. *Binan̄ Goonj: Bridging Cultures in Aboriginal Health* (Eckermann et al., 2006), following Kelly and Sewell (1991), argues that communities, rather than hospitals, are best positioned to create paths for wellness as they offer people space (geographic location), place (a space where identities and belonging are produced), and base (space and place where people have economic, social, and political agency). In addition, there have been a number of local affirmative health programs, led by Aboriginal people for Aboriginal people, that privilege local cultural knowledge and practices.

Community health models have their obvious advantages. They offer an approach in which power paradigms are inverted and Aboriginal epistemologies are normative. However, the majority of Aboriginal Australians live in major urban centres where health care for serious illnesses continues to be delivered in hospitals. As a consequence this paper suggests that a framework for decolonising health care within an urban hospital setting remains important. The recent study *Managing Two Worlds Together* (Dwyer et al., 2011) noted that 4% of all hospitalisations from 2013 to 2014 were Aboriginal or Torres Strait Islander people, although they make up only 2.5% of the national population. It further noted that while Indigenous adults are almost twice as likely as non-Indigenous adults to present to a city hospital, they are more than 6 times as likely to present to a country hospital. From these statistics it seems that city hospitals may be *both* an essential place for delivering health care for Indigenous populations, *and* an alienating and undesirable destination. Primary concerns of patients were about difficulties of organizing transport to and accommodation near hospitals, disconnection from family, worries about cultural aspects of care (especially dying off Country), and perceptions of systemic racism (Dwyer et al., 2011). Health care professionals' observations of the experiences of Indigenous patients and their families were similar, although they also identified concerns about compliance to clinical regimes, difficulties gaining consent for treatment, and the importance of Aboriginal health workers as advocates and cultural brokers, which they acknowledged is a broad, stressful, and burdensome role (Dwyer et al., 2011). Staff reported glimmers of accommodation to Indigenous ways of doing health, where occasionally traditional healers have performed smoking ceremonies to cleanse rooms and move spirits on as a way of

allaying fear and anxiety. But on the whole cultural practices were seen as secondary to Western models of care and ignored or excluded if there were perceived conflicts (Dwyer et al., 2011). Hovey et al. (2014) argue that in Canada, health care in hospitals is increasingly “culturally sensitive” but not yet “culturally safe,” as medicine continues to be filtered through a Western paradigm that perpetuates colonisation. In New Zealand, efforts to improve cultural safety have resisted cultural awareness education, out of concern regarding ossifying stereotypes, in favour of increasing opportunities for Maori people to lead health care programs (Ellison-Loschmann & Pearce, 2006). Unlike Canada and New Zealand, which signed at least some treaties with their First Peoples, Australia’s colonisation is marked by a process of unrivalled dislocation from land and dispossession of culture. A framework for hospital-based Indigenous health care must not only improve cultural awareness and increase the representation of Indigenous staff in delivering care (following Kelly & Sewell, 1991), it must develop new models for care and new ways of providing “space, place, and base” for Aboriginal people within urban hospitals.

A New Framework

Three of the authors of this paper are clinicians with Aboriginal heritage in a tertiary, hospital-based, treatment-nonresponsive developmental neuropsychiatry program (DNP) at the Royal Children’s Hospital (RCH) in Melbourne. This program works closely with the Aboriginal Liaison Unit, Wadja Aboriginal Family Place. At present, the authors are working to establish an Aboriginal Knowledge Place that augments Wadja Aboriginal Family Place. The following are the elements under consideration as they develop a new framework to bring Aboriginal ways of knowing, doing, and being into dialogue with Western medicine.

Space

In urban hospitals there is little spatial certainty for any patient who is shuffled variously between waiting rooms, outpatient clinics, emergency department trolleys, and inpatient beds. But for Aboriginal people the sense of disempowerment can be magnified by the cultural strangeness of Western medical care and geographic isolation from family and community. Most Australian hospitals have Aboriginal liaison units operated by social work departments to alleviate these anxieties. Wadja Aboriginal Family Place, for example, has a spatial presence within the institutional context of the hospital that Aboriginal people can use as a geographic safe haven. Outpatient clinics can be run from the centre and there is also a comfortable space where families can spend time with their “mob” and an outdoor area to escape from the confines of the hospital’s interior. But the centre is small and isolated in the hospital context and is not easily located by visitors. Maintaining and augmenting such a facility is an ongoing challenge in an increasingly stringent economic context. It is interesting to consider that hospitals generally are increasingly confining. Over the past 150 years, hospitals on average have decreased in ward space by 70% (Connellan et al., 2013).

The challenge of getting to hospitals is also often significant. Many hospitals are located in the heart of cities a long way from the peripheral suburbs where marginalized communities are

often found, and the journey to hospital takes time, organisation, and money. It requires either negotiating public transport (which can be challenging for people who are unwell) or driving and parking, which can be extremely expensive. Once patients leave hospital and make their journey back home, there are few reliable networks to ease the transition between hospital and communities and to support the path back to wellness.

The spatial challenge for urban hospitals is thus twofold: to provide spaces that are culturally safe havens within the hospital infrastructure, ideally including temporary accommodation of families who are supporting inpatients; and to develop better processes of connection with community-based care once patients are discharged.

Place

Aboriginal cultural identity formation is closely linked to space. As Kelly and Sewell (1991) argue, the spaces where identities and belonging are produced become “places.” Three Indigenous themes of place are particularly relevant for health: Country, totem, and *Story* (see Glossary). These are being incorporated, in genuine dialogue with Western health practice, into a novel clinical service in the DNP by three of the authors.

Country is central for Australian Aboriginal identity—not generalisable or abstract but specific, local, and immediate. Specific landforms and waterways convey evidence of the ongoing action of creator spirits (see McGaw & Pieris, 2014). The relationship between people and land is one of mutual belonging. Indigenous concepts of Country, which hold that respecting, maintaining, and caring for Country is paramount, are diametrically opposed to the Western paradigm of land as property (Cunningham & Stanley, 2003). Social responsibility to one’s kin is expressed through the rituals enacted in the sacred landscape, according to Langton (2005). Colonial laws have displaced Indigenous people from Country, and in turn separated people from their kin, totems, and sacred Stories. Indigenous dislocation was arguably greatest in the southeastern states of Victoria and Tasmania, although there were no parts of the continent that were left untouched.

Part of caring for Country involves caring for totem animals, trees, and plants. Totems are complex, multifaceted, and difficult to describe outside of Aboriginal culture. They are a primary means of responsibly caring for place, managing and balancing multiple ecological systems, and maintaining Story. The term *totem* originated from the Aboriginal Peoples of the United States and Canada and has become universally used by Western scholars to describe the ongoing system of spiritual and practical connection between Indigenous people and place, animals, and plants (Grieves, 2009). The totemic system arose from the ancestral law developed at the time of creation. It reinforces human beings and the natural world as one indivisible whole; the same matter but different form. Through ritual, ceremony, and customs Aboriginal people and their totems and ancestors become fused in a single reality. This fused reality is lived out through maintaining the relationship with the totem species, for example, and with the sacred sites where the totem is connected with the emplaced ancestral spirits. Although the majority of Victorian Aboriginal people were displaced from Country and cultural practices through the

colonial period, totemic ideas persist. In some instances they have been diluted to a concept of allegiance, not dissimilar to non-Aboriginal “tribal” allegiances such as supporting a football team, but for others, totems remain an organising principle for Aboriginal tribes, clans, and families and give rise to persistent customs, ceremonies, and rituals. These actively remember the achievements of the ancestral spirits and give the initiated identity, meaning, and purpose through ongoing connection with them. If one’s totem is an animal, you are responsible for nurturing and caring for that animal. One studies its appearance, behaviour, coping styles, movements, sounds, and living patterns and learns from it and emulates its feats. Through ceremony, custom, and ritual one adds to the life of the animal and so too is enhanced in return.

Story is another important means for connecting with and caring for Country and its emplaced ancestors. A marker of maturity in Aboriginal culture is to know one’s Story, enact it “on Country,” and upon one’s death become the totemic ancestral spirit and return to one’s Story place. Particularity is crucial. Specific people in specific places know specific parts of Story given to them because of who they are becoming within a family, clan, and tribal group. Story is independent of linear time. There is no past or future—just present ongoing Story. According to Watson (2009), English translations such as Dreaming and Dreamtime story do not capture the full meaning of Story. She notes that Western understandings of place as a commodity that can be bought and sold is at odds with the relational understanding of Country that underpins Indigenous place making. Stories recount the source of a person and their kin through their ancestors, and generally must be told in the location where the ancestors are emplaced forever. These sacred Stories remain inextricably linked with law and morality and govern interpersonal attitudes and behaviour. Exact repetition is of paramount importance; this practice has enabled Stories to be maintained faithfully for thousands of years. The carrier of a Story is accorded privileges, including rights to land connected with a Story and the right to decide when and to whom to hand on a Story. But there are also responsibilities. Strict rules must be followed about their transfer to others: to whom, and through what modes of practice. In Stories place is central to interpersonal ethics, law, and land rights. To be whole, the Aboriginal person must know his or her Story. Given the fragmentation of Indigenous culture through the era of colonisation in Victoria, many Stories are no longer maintained. The authors of this paper argue that this loss is a poorly understood factor contributing to the dire statistics on Indigenous health.

So how might Country, totem, and Story telling become part of a therapeutic relationship? Brearley and Hamm (2009) developed what they describe as a research methodology that sits between Indigenous and non-Indigenous knowledge systems. The methodology pairs story telling with responsive *deep listening* (see Glossary), which has its own word in many Aboriginal languages: *ngarrwa nyarrwa* in the Wurrung language of the first author. Deep listening begins with a commitment to respecting Indigenous knowledge systems as different yet equal. Intuition, spiritual experience, and unverifiable conversations can be central to communicating and understanding Indigenous knowledge. While these have a currency in psychodynamic traditions, they are often perceived as problematic in current multimodal evidence-based approaches. Brearley and Hamm (2009) argue that deep listening develops

through empathy and unfolds over time. While it is core to Indigenous ways of knowing and being, when practised by non-Indigenous people it offers a path toward reconciliation. Egyptian scholar Mehrez (1991) argues that it is only when colonisers situate themselves in the narrative of dispossession that the work of decolonisation can begin. Similarly, this paper argues that wellness models for health in Australia should include opportunities for Aboriginal people to move beyond the confines and interiority of hospital buildings to reconnect with Country. It also argues for the benefits of enlisting relational totems as an implicit part of the network of healing relationships for Aboriginal patients.

Base

As Kelly and Sewell (1991) write, spatial transformation and opportunities to form identity through embodied ritual practices on Country are not enough. Aboriginal people also need economic, social, and political agency within the places they inhabit. This is easier to achieve in community-based health programs than hospitals. Many patients, regardless of cultural background, feel disempowered within hospital settings, where illness rather than wellness predominates. However, there are some key steps that hospitals can take.

First, a co-leadership model for Aboriginal and non-Aboriginal ways of doing health is necessary so that genuine and meaningful dialogue can occur rather than merely helping Aboriginal people to better comply with non-Aboriginal health systems. Second, a governance group of Aboriginal Elders is crucial to provide (a) a culturally safe place for the above dialogue to occur, (b) cultural oversight and day-to-day supervision for the varied healing practices within Aboriginal culture, and (c) leadership in the political and economic processes of the hospital and health system at large. Traditional healers would ideally be part of this group. Finally, hospitals must provide ongoing cultural awareness and safety training for all staff in order to maintain genuine Aboriginal and non-Aboriginal dialogue.

Methods, Preliminary Results, and Discussion

Towards an Aboriginal Knowledge Place

Although there is no funding yet for full implementation of an Aboriginal Knowledge Place, important first steps have been taken, which will be described in more detail below. To summarise, the authors of this paper began a process of statewide consultation with leaders within the Aboriginal community in Victoria 18 months ago to seek their guidance and support for such a venture. The RCH has since engaged an external consultant to do a cultural safety audit and make recommendations. The authors of this paper who are involved in clinical care have ethics approval for this work as a clinical quality improvement initiative. So far 10 young people and their families have been managed in this new way. Initial results are very promising. Further formal qualitative and quantitative evaluations are planned once 50 or more cases have been managed through the program. These will be published in due course.

The first step has been to consult with Aboriginal leaders across the state of Victoria. So far a dozen key Aboriginal leaders have been involved. Unlike meetings within non-Indigenous organisations which are often organized by email, brokered in groups with organizational hierarchies, and carried out with a clear agenda and time keeping, this consultation has followed the model of community-based Indigenist health care in which Aboriginal ways of knowing, doing, and being are central. The process of consultation has been broad and inclusive. Aunties and Uncles from Melbourne and regional Victoria as well as directors of advocacy groups for Aboriginal health and welfare have been included in discussions. The latter are well positioned to advocate for and lead change within health, education, and welfare departments. The first author has personally met with them all—sometimes on Country, other times at Wadja Aboriginal Family Place and the gardens around the hospital or at their place of work. The meetings have allowed opportunities for yarning.

The model that has evolved through the consultation to date is for an Aboriginal Knowledge Place that can develop an alternative approach in which Indigenous ways of knowing and being are enlisted to augment Western biopsychosocial treatments, especially for treatment-nonresponsive cases. The existing culture, ethos, and clinical service delivery model of the Wadja Aboriginal Family Place is preserved and extended by the Aboriginal Knowledge Place in the following ways:

1. A co-directorship model involving Aboriginal and non-Aboriginal directors should be established, as in extant world-leading Indigenous cultural centres.
2. An advisory group of Victorian Traditional Owner Aboriginal Elders representing the North–South–East–West of Victoria should be convened to meet with the directors quarterly or more frequently as needed to deal with roadblocks to delivering health outcomes.
3. Aboriginal culture, especially Country, totem, and Story, should exist in genuine dialogue with Western health care models for Aboriginal young people seen at RCH.
4. Care arising from this holistic genuine dialogue needs to extend back into the communities where Aboriginal young people live, so that Aboriginal and non-Aboriginal models of health, education, welfare, and justice are advocated for and integrated.
5. It is hoped that teaching programs for Aboriginal and non-Aboriginal people will arise from this genuine dialogue and be made available for Aboriginal and non-Aboriginal health, education, welfare, and justice staff.
6. Research programs should use qualitative and quantitative measures to analyse outcomes from the Aboriginal Knowledge Place database, providing unique insights. Research insights would be fed back iteratively and seamlessly through the teaching and advocacy/integration practices. It is envisaged that such an Aboriginal Knowledge Place could nurture equity and innovative health care practice from which all can learn and benefit.

As with all ventures of this nature, resourcing is the most difficult hurdle to overcome. Formerly, the RCH and Aboriginal Hostels Limited jointly ran an accommodation for Aboriginal families across the road from the hospital at an Aboriginal hostel. It was considered a culturally safe place for families to stay while their children received treatment, but it was closed down for

reasons of funding. Employing a Woiwurrung Elder to welcome people to Country is also considered too costly. In light of this, the team has strengthened links between the DNP and community culture-based programs that already exist and achieve excellent outcomes in improving health. They are also encouraging the inclusion of cultural discussions and encounters with Indigenous patients and their families to facilitate a broader clinician–client engagement and deeper mutual trust that enables the journey to health.

The DNP is a tertiary referral outpatient clinic that is led by a psychiatrist (the first author) and clinical and educational psychologist (third author) who work closely with the head of Koori Mental Health (fourth author). It receives referrals from metropolitan and regional schools, primary health care teams, and secondary specialist services in the state of Victoria, Australia. It conducts a comprehensive assessment of cases using integrated information from detailed multi-informant clinical interviews and examination and standardized biopsychosocial measures. Treatments vary from case to case, but they often involve a 6-month synergistic systematic trial of first- to third-line medications to enhance engagement in individual and group cognitive behaviour therapy (CBT) programs involving parent and teacher management training. The clinic has treated over 1,000 cases over the past 5 years. Successful outcomes are achieved in 72% of referred cases, previously deemed treatment nonresponsive (for more details about the DNP, see http://www.rch.org.au/acpu/about_acpu/Developmental_Neuropsychiatry_Program/). In contrast, 31% of Aboriginal young people managed through the clinic had successful outcomes prior to commencing an “Indigenist dialogue” as part of care.

Under the new model, Indigenist dialogue, in which Indigenous ways of knowing and being are enlisted to augment Western biopsychosocial treatments, unfolds when opportunities arise. If a client reveals during assessment and/or treatment sessions that they are Indigenous, this is recognised and reinforced through the clinician synchronously sharing, mirroring, and reinforcing the importance of their own and the client’s Aboriginal heritage. The clinician is then able to draw parallels between Western health interventions and Aboriginal cultural ways of doing health and being healthy. Sometimes, care is delivered walking or sitting with a chaperone in the gardens, rather than in small windowless consulting rooms. Clinical quality improvement audit outcomes seem promising: 10 previously treatment-nonresponsive Aboriginal patients have made marked improvements. The young people and their families seem to develop a greater faith in the formulation and treatment planning processes to aid successful treatment outcomes. Furthermore, in more complex ways, engaging cultural knowledge and identity through Indigenous perspectives of place equally facilitates the journey to health. Each young person has become progressively more focused and centred, deeply aware of their rights inexorably linked with their responsibilities to Country, totem, and Story.

There is a clear advantage for the clinician to have Aboriginal heritage when engaging in such a dialogue. Furthermore, the availability of Aboriginal health workers to see cases alongside non-Aboriginal clinicians can be invaluable. Although, it remains a day-to-day dilemma that their numbers are too few in the health service system. Despite the particularity of Aboriginal cultural understandings of place, dialogue between Aboriginal people from different

language groups and cultural traditions is time honoured and expected. While Country, totem, and Story are important in the journey to health for some, others in the Aboriginal community might construct their social identity differently. Hence the importance of deep responsive listening as part of the clinician–patient dialogue.

A comprehensive evaluation is being developed to determine what parts of the new model of care work best and what aspects need to be reformulated. Qualitative information will be collected pre- and post-intervention by clinicians through interviews with each young person seen in the Aboriginal Knowledge Place program and the key family members involved in their care on a day-to-day basis. Community Elders will be invited to provide qualitative feedback and insights. They will be engaged in running and supervising cultural practices and aiding connections between the Aboriginal Knowledge Place work at the hospital and the community where each young person and family live. In addition, each clinical case manager and the senior managers of each involved service will be interviewed to add their views to all the qualitative information obtained. Similarly, quantitative data will be collected pre- and post-intervention about the Aboriginal Knowledge Place program by adding measures about health, education, and welfare outcomes to existing hospital and service measures already collected as part of the Victorian Government key performance indicators. Each young person, involved family members, clinical case manager, and senior service manager will complete this quantitative measure that has been formulated for their age and educational level. Together these data will enable us to work towards putting together a randomised controlled trial evaluation of the Aboriginal Knowledge Place.

Creating a cultural safe space is an essential starting point. The RCH has engaged a national Indigenist therapeutic organisation to work with its executive to improve cultural safety in the hospital. But a range of other practices has been proposed by Elders around the concept of the Aboriginal Knowledge Place. Initiatives already underway include formal referral pathways for ongoing care of Aboriginal young people served at the hospital with a community-based Aboriginal wellness and connection practice, Wayapa (<http://www.wayapawuurk.com>). In lieu of a *Welcome to Country* (see Glossary), there has been a suggestion by Elders to invest in Welcome to Country blankets for the beds of Aboriginal young people and their families. These blankets would be a traditional patchwork rug made from possum pelts, on which the hide side is etched with markers of Country. Two of the Elders involved in developing the Aboriginal Knowledge Place strategy have been involved in making possum skin cloaks with young people in out-of-home care as part of a community healing program (<http://www.vacca.org/services/strengthening-culture/possum-skin-cloak-project-2013/>). Another Elder has been instrumental in developing *yarning* circles (see Glossary) in community, which are focused on women’s cultural identity, men’s cultural identity, lateral violence, domestic violence, alcohol/substance abuse disorders, and parenting skills to foster the next generation.

Ideas for transforming the space of the hospital include: Welcome to Country floor murals and plaques at the hospital entrance and an Indigenous garden in the outdoor area adjacent to Wadja Aboriginal Family Place. The garden would have medicinal plants, spaces for

smoking and water ceremonies, and places for storytelling, deep listening, and healing practices. This would be the starting place for Aboriginal health trails that could be developed in Royal Park, the gardens where the hospital is situated. A number of community organisations have been involved in projects where walking Country is used as a health-based practice (Mitchell, 2012). Already, young people and their families served at the hospital are being referred to on-Country learning walks that are conducted by senior Aboriginal people and Elders at various rural locations in Victoria.

Conclusion

The Aboriginal Knowledge Place model is nested within a larger dialogue led by Aboriginal leaders nationwide. A national action plan to address Indigenous youth suicide in Australia is imminent (Brennan, 2015). The *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide* (People Culture Environment, 2014) has emphasised the same all-encompassing connection between culture, health, healing, and resilience for Australian Aboriginal people. It is important to establish a systematic database to record, organise, and foster this future development. If findings of Indigenist–Western health dialogue continue to show promise, the model of an Aboriginal Knowledge Place could be extended to other hospitals around Australia. Qualitative and quantitative data collected pre- and post-intervention and randomised controlled trial evaluations will be crucial. The Binaḡ Goonj (Eckermann et al., 2006) initiative is appropriate because it articulates the need for economic, political, and social agency in order for Indigenous communities to be healthy. A database which emerges from the Aboriginal Knowledge Place could provide an important line of evidence for funding so that hospital outpatient-based health and mental health management can extend into each Aboriginal young person's community of origin through an advocacy model built on genuine and explicit dialogue. Future teaching programs based on the lessons learned from the action–reflection Indigenist dialogue need to inform extant hospital policy, clinical practice, academic domains, and Aboriginal communities. If all of these objectives can be achieved, hospitals will be nurtured by Aboriginal Knowledge Places that support deep responsive listening and transforming dialogue for the benefit of all—Aboriginal and non-Aboriginal alike. The literature on mental health and architecture published in the last decade reveals that the connection between health and living environments is not confined to those with Aboriginal heritage. Perhaps Indigenous ways of knowing and being provide a timely critique of the configuration of space for the delivery of Western health care for all.

References

- Anderson, I., Crengle, S., Kamaka, M. L., Chen, T.-H., Palafox, N., & Jackson-Pulver, L. (2006). Indigenous health in Australia, New Zealand, and the Pacific. *The Lancet*, 367(9524), 1775–1785. doi:10.1016/s0140-6736(06)68773-4

- Australian Bureau of Statistics. (2010). *Population characteristics, Aboriginal and Torres Strait Islander Australians, 2006* (Reissue). Canberra, AU: Author.
- Australian Government. (2008). *Apology to Australia's Indigenous Peoples*. Retrieved from <http://australia.gov.au/about-australia/our-country/our-people/apology-to-australias-indigenous-peoples>
- Baxendell, N. (1997). *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra, AU: Australian Bureau of Statistics.
- Beck, S. (1953). The science of personality: Nomothetic or ideographic? *Psychological Review*, 60(6), 353–359. doi:10.1037/h0055330
- Bloch, S. (1997). Psychiatry: An impossible profession? *Australian & New Zealand Journal of Psychiatry*, 31(2), 172–183. doi:10.3109/00048679709073818
- Bostock, J. (1924). Insanity in the Australian Aboriginal and its bearing on the evolution of mental illness. *Medical Journal of Australia*, 2, 459–464.
- Brearley, L., & Hamm, T. (2009). Ways of looking and listening: Stories from the spaces between Indigenous and non-Indigenous knowledge systems. In E. Grieson & L. Brearley (Eds.), *Creative arts research: Narratives of methodologies and practices* (pp. 33–54). Rotterdam, The Netherlands: Sense.
- Brennan, B. (2015, July 24). Suicide prevention plan for Indigenous communities close, leaders say [Radio interview]. *AM with Michael Brissenden*. Retrieved from ABC News website: <http://www.abc.net.au/am/content/2015/s4279903.htm>
- Bristow, W. (2011). Enlightenment. In E. N. Zalta (Ed.), *Stanford encyclopedia of philosophy* (Summer 2011 Edition). Retrieved from <http://plato.stanford.edu/archives/sum2011/entries/enlightenment/>
- Cawte, J. (1963). Assimilation and its discontents: Case histories illustrating problems of Aboriginal mental illness. *Australasian Psychiatric Bulletin*, 4, 17–18.
- Cawte, J. (1988). The devil's dozen: 13 Aboriginal depressions. *Aboriginal Health Worker*, 12, 19–28.
- Clough, A., D'Abbs, P., Cairney, S., Gray, D., Maruff, P., Parker, R., & O'Reilly, B. (2004). Emerging patterns of cannabis and other substance use in Aboriginal communities in Arnhem Land, Northern Territory: A study of two communities. *Drug and Alcohol Review*, 23(4), 381–390. doi:10.1080/09595230412331324509
- Connellan, K., Gaardboe, M., Riggs, D., Due, C., Reinschmidt, A., & Mustillo, L. (2013). Stressed spaces: Mental health and architecture. *Health Environments Research & Design Journal*, 6(4), 127–168. doi:10.1177/193758671300600408
- Council of Australian Governments. (2008). *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*. Retrieved from Council on Federal Financial Relations website: http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/national_partnership.pdf

- Cunningham, C., & Stanley, F. (2003). Indigenous by definition, experience, or world view: Links between people, their land, and culture need to be acknowledged. *The BMJ*, 327(7412), 403–404. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC188479/>
- Dingwall, K. M., & Cairney, S. (2011). Detecting psychological symptoms related to substance use among Indigenous Australians. *Drug and Alcohol Review*, 30(1), 33–39. doi:10.1111/j.1465-3362.2010.00194.x
- Dudgeon, P., Milroy, H., & Walker, R. (Eds.). (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed.). Retrieved from Aboriginal Health website: [http://aboriginal.telethonkids.org.au/kulunga-research-network/working-together-2nd-edition-\(1\)/](http://aboriginal.telethonkids.org.au/kulunga-research-network/working-together-2nd-edition-(1)/)
- Dwyer, J., Kelly, J., Willis, E., Glover, J., Mackean, T., Pekarsky, B., & Battersby, B. (2011). *Managing two worlds together: City hospital care for country Aboriginal people—Project report*. Adelaide, AU: Flinders University.
- Eckermann, A. K., Dowd, T., Chong, E., Nixon, L., Gray, R., & Johnson, S. (2006). *Binarj Goonj: Bridging cultures in Aboriginal health* (2nd ed.). Marrickville, AU: Elsevier.
- Edwards, R., & Madden, R. (2001). *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra, AU: Australian Bureau of Statistics.
- Eley, D., Young, L., Hunter, K., Baker, P., Hunter, E., & Hannah, D. (2007). Perceptions of mental health service delivery among staff and Indigenous consumers: It's still about communication. *Australasian Psychiatry*, 15(2), 130–134. doi:10.1080/10398560601121017
- Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care Among New Zealand's Maori population. *American Journal of Public Health*, 96(4), 612–617. doi:10.2105/AJPH.2005.070680
- Garrouette, E. (2005). Defining “radical indigenism” and creating an American Indian scholarship. In S. Pfohl, A. Van Wagenen, P. Arend, A. Brooks, & D. Leckenby (Eds.), *Culture, power, and history: Studies in critical sociology* (pp. 169–198). Boston, MA: Brill.
- Gault, E. I., Krupinski, J., & Stoller, A. (1970). Psychosocial problems of adolescent Aborigines in Victoria. *Australian & New Zealand Journal of Psychiatry*, 4(1), 24–33. doi:10.3109/00048677009159304
- Grievies, V. (2009). *Aboriginal spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing* (Discussion Paper No. 9). Darwin, AU: Cooperative Research Centre for Aboriginal Health.
- Habermas, J. (1989). *The structural transformation of the public sphere: An inquiry into a category of bourgeois society* (T. Burger & F. Lawrence, Trans.). Cambridge, MA: MIT Press.

- Holland, C. (2014). *Progress and priorities report 2014*. Close the Gap Campaign Steering Committee. Retrieved from Australian Human Rights Commission website: <https://www.humanrights.gov.au/publications/close-gap-progress-and-priorities-report-2014>
- Hovey, R. B., Delormier, T., & McComber, A. (2014). Social-relational understandings of health and well-being from an Indigenous perspective. *International Journal of Indigenous Health, 10*(1), 35–54.
- Human Rights and Equal Opportunity Commission. (1997). *“Bringing them home”: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra, AU: Sterling Press.
- Hunter, E. M. (1991). The social and family context of Aboriginal self-harmful behaviour in remote Australia. *Australian & New Zealand Journal of Psychiatry, 25*(2), 203–209. doi:10.3109/00048679109077736
- Hunter, E. (1993). Aboriginal mental health awareness: An overview—Part 2. *Aboriginal and Islander Health Worker Journal, 17*(1), 8–10.
- Hunter, E. (2004). Communication and Indigenous health. *Australian Doctor, 4*, 35–42.
- Kelly, A., & Sewell, S. (1991). *With head, heart and hand: Dimensions of community building*. Brisbane, AU: Boolarong.
- Langton, M. (2002). The edge of the sacred, the edge of death: Sensual inscriptions. In M. Wilson & B. David (Eds.), *Inscribed landscapes: Marking and making place* (pp. 253–269). Honolulu, HI: University of Hawai‘i.
- Langton, M. (2005). Sacred geography. In M. Charlesworth, F. Dussart, & H. Morphy (Eds.), *Aboriginal religions in Australia: An anthology of recent writings* (pp. 135). Aldershot, UK: Ashgate.
- Lavallée, L. F. (2009). Practical application of an Indigenous research framework and two qualitative Indigenous research methods: Sharing circles and Anishnaabe symbol-based reflection. *International Journal of Qualitative Methods, 8*(1), 21–40.
- Lee, K. S. K., Conigrave, K. M., Clough, A. R., Dobbins, T. A., Jaragba, M. J., & Patton, G. C. (2009). Five-year longitudinal study of cannabis users in three remote Aboriginal communities in Arnhem Land, Northern Territory, Australia. *Drug and Alcohol Review, 28*(6), 623–630. doi:10.1111/j.1465-3362.2009.00067.x
- Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for Indigenous and Indigenist re-search. *Journal of Australian Studies, 27*(76), 203–214. doi:10.1080/14443050309387838
- McGaw, J., & Pieris, A. (2014). *Assembling the centre: Architecture for Indigenous cultures*. London, UK: Routledge. doi:10.4324/9781315746647
- McKendrick, J. H., Thorpe, M., Cutter, T. N., Austin, G., Roberts, W., Duke, M., & Chiu, E. (1990). A unique mental health network for Victorian Aboriginal people. *Medical Journal of Australia, 153*(6), 349–351.
- Mehrez, S. (1991). *The bonds of race*. Ithaca, NY: Cornell University Press.

- Mitchell, P. (2012, March 4). Coming full circle to heal the hurt. *The Age (Victoria)*. Retrieved from <http://www.theage.com.au/victoria/coming-full-circle-to-heal-the-hurt-20120303-1u9n0.html>
- Peeters, L., & Kelly, K. (1999). *Reclaiming identity through the pain: What helps and hurts in social and emotional wellbeing: An Aboriginal community perspective* (Aboriginal Health and Medical Research Monograph Series). Canberra, AU: Commonwealth of Australia.
- People Culture Environment. (2014). *The Elders' report into preventing Indigenous self-harm and youth suicide*. Retrieved from Culture is Life website: <http://www.cultureislife.org/the-elders-report/>
- Petchkovsky, L., & San Roque, C. (2002). Tjunguwiyanytja, attacks on linking: Forced separation and its psychiatric sequelae in Australia's "stolen generations." *Transcultural Psychiatry*, 39(3), 345–366. doi:10.1177/136346150203900304
- Purdie, N., Dudgeon, P., & Walker, R. (Eds.) (2010). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Canberra, AU: Commonwealth of Australia.
- Rigney, L.-I. (1999). Internationalization of an Indigenous anticolonial cultural critique of research methodologies: A guide to Indigenist research methodology and its principles. *Emergent Ideas in Native American Studies*, 14(2), 109–121. doi:10.2307/1409555
- Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London, UK: Zed Books.
- Standing Bear, Luther. (1933). *Land of the spotted eagle*. Lincoln, NE: University of Nebraska.
- Swan, P., & Raphael, B. (1995). *Ways forward: National Aboriginal and Torres Strait Islander mental health policy: National consultancy report*. Canberra, AU: Australian Government Publishing Service.
- Turale, S. (1994). Ballarat Koorie life experience: Learning about Koorie perceptions of mental health and illness. *Australian Journal of Mental Health Nursing*, 3(1), 16–28.
- Watson, I. (2009). Sovereign spaces, caring for country, and the homeless position of Aboriginal peoples. *South Atlantic Quarterly*, 108(1), 27–51. doi:10.1215/00382876-2008-021
- West, R., Stewart, L., Foster, K., & Usher, K. (2013). Through a critical lens: Indigenist research and the Dadirri method. *Qualitative Health Research*, 22(11), 1582–1590. doi:10.1177/1049732312457596
- Wilson, S. (2009). *Research is ceremony: Indigenous research methods*. Halifax, NS: Fernwood.
- Ypinazar, V. A., Margolis, S. A., Haswell-Elkins, M., & Tsey, K. (2007). Indigenous Australians' understandings regarding mental health and disorders. *Australian & New Zealand Journal of Psychiatry*, 41(6), 467–478. doi:10.1080/00048670701332953