School of Psychology

Promoting the Social and Emotional Wellbeing of West Kimberley Aboriginal Children and Youth

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature: …….

Date: …….

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ABSTRACT

Aboriginal young people experience a high rate of family violence, alcohol and drug misuse, suicide, sexual abuse, and socioeconomic disadvantage (Gordon, Hallahan & Henry, 2002; Hunter, 1990, 1991c; Kimberley Aboriginal Medical Services Council, 1999; Memmott, Stacy, Chambers & Keys, 2001; Swan & Raphael, 1995). Over the last decade a burgeoning array of policy, services and programs have been developed to combat the social and emotional problems in Aboriginal communities. Despite some successes, Aboriginal children and youth consistently demonstrate poorer outcomes than non-Aboriginal youngsters across most domains of living, including health, mental health, education and vocation (Zubrick et al., 2005). While the evidence-base related to problems in Aboriginal communities has expanded, there is a deficit in knowledge about practical and sustainable interventions to build strengths in remote young Aboriginal people and families, to promote youth and community wellbeing. Even less has been done on the ground to assist remote Aboriginal communities to take action in tackling the problems they face (Atkinson, Bridge & Gray, 1999; Kimberley Aboriginal Medical Services Council & Westerman, 2002; National Aboriginal Health Strategy Working Party, 1989).

This qualitative participatory action research project conducted in the West Kimberley Western Australia from 2001 to 2004 was in collaboration with agencies based in Broome and the Bardi people of Ardyaloon Community, One Arm Point. The investigation aimed to (1) identify and explain the mental health and social and emotional problems affecting Aboriginal young people and families living in remote communities in the West Kimberley; and (2) identify and describe goals and methods for intervention to promote social and emotional wellbeing and build resilience in

young people and communities. The third aim was to feed back and culturally validate the research findings. The overarching goal of this project was to work in partnership with Ardyaloon Community in prioritising community-based solutions to youth problems. An Aboriginal Project Advisory Group was formed to guide the research and several local project assistants were employed to assist with the field work. The project involved three studies. Overall, 32 Broome-based youth, parents and service providers, and 59 Elders, parents, youth and service providers from One Arm Point were involved in interviews and discussion groups. The findings were discussed and validated by 101 agency and community people. The results indicate a number of risk and resilience factors operating across the individual, family, community and socio-political sphere, including cultural and historical factors influencing youth wellbeing. From the findings, a model for community-based mental health promotion intervention was developed to address youth problems and build strengths prioritised by Ardyaloon Community.

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INTRODUCTION

Aboriginal people comprise about 2.3% of the Australian population. Young people below the age of 15 years constitute 38% of the total Aboriginal population (Australian Bureau of Statistics, 2006). Aboriginal people are the most disadvantaged cultural group in the nation (McKendrick et al., 1990). The *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*: *Ways Forward* (Swan & Raphael, 1995, p. 1) revealed that mental health problems are an "extensive" problem for Aboriginal communities with few resources and programs available to adequately deal with the problem. Despite this, few studies have investigated the mental health and social and emotional wellbeing of Aboriginal young people, even though up to a third of young people are estimated to have mental health problems.

The current research aimed to identify and explain the social and emotional problems impacting on Aboriginal children and youth living in remote communities in the West Kimberley region of Western Australia (WA). A second aim was to identify and describe community-based strategies to improve wellbeing and build resilience in young Aboriginal people and families.

The field of Aboriginal mental health research and intervention, like all other areas of Aboriginal affairs, has been strongly influenced by the attitudes, policies and practices of mainstream society directed toward Aboriginal people. Early ethno-psychiatric research dating back to the 1960s attempted to observe and define mental health disorders in Aboriginal children and youth utilising Western methods and

theoretical constructs of disorder (e.g., Jones, 1972; Kidson & Jones, 1968; Nurcombe & Cawte, 1967; Smith, 1999; Webber, 1980). These researchers encountered Aboriginal people in rapid and severe social and cultural upheaval. High rates of behavioural disorders, learning difficulties and social maladjustment were identified in children and youth. However, theoretical and methodological inadequacies such as a bias toward Western psychiatric constructs of disorders presented a limited interpretation of Aboriginal mental health and wellbeing.

The international civil rights movement paved the way for Aboriginal activism at home, with Aboriginal and some non-Aboriginal people announcing the deplorable conditions of Aboriginal communities, with public demands of social justice for all Aboriginal people (Brady, 2004). The 1967 Commonwealth Referendum finally granted citizenship rights to Aboriginal people. A shift in government policy from assimilation and integration to self-determination and self-management in the 1970s and 1980s saw the origins of Aboriginal involvement in decision making and increased participation of Aboriginal people in their own affairs (Centre for Aboriginal Studies Curtin University of Technology, 2001). The final report of the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC: Johnston), released in 1991, highlighted the strong association of historical, cultural, socioeconomic disadvantage and ongoing racism and discrimination, with the disproportionately high incarceration of Aboriginal people compared with non-Aboriginal people and the resulting higher rate of Aboriginal deaths in custody (Hunter, 1997; Pearson, 2003). The recommendations from the RCIADIC advocated self-determination as a means for Aboriginal people to take meaningful control over their situation to improve individual and community wellbeing. The publication of

the first *National Aboriginal Health Strategy* (NAHS) in 1989 and the expansion of the National Aboriginal Community Controlled Health Organisation (NACCHO) in the early 1990s saw a political and ideological shift in Aboriginal health and mental health policy and planning. At this time more control was given to Aboriginal people through the development of Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Medical Services (AMSs), as well as the employment of Aboriginal Health Workers (AHWs) across Australia (Hunter, 1997).

Aboriginal mental health research and practice in the 1990s were strongly influenced by discussions and recommendations from the first *National Aboriginal Mental Health Conference: Our Way* held in 1993 and the following *National Consultancy on Aboriginal and Torres Strait Islander Mental Health* (*The Consultancy*). For the first time Aboriginal and non-Aboriginal health and mental health professionals collaboratively approached Aboriginal mental health issues. Aboriginal people spoke publicly about the debilitating impact of past policies and practices on the mental health and wellbeing of their people. Following *The Consultancy*, Swan and Raphael (1995) published *Ways Forward*, a report detailing information for the first National Aboriginal Mental Health Policy and Plan. *Ways Forward* highlighted the lack of understanding non-Aboriginal policy-makers and helping professionals had in regards to Aboriginal perspectives on health, mental health and wellbeing. The report defined a holistic view of mental health, incorporating the impact of cultural, spiritual, mental, emotional, physical, social, political and historical factors on the wellbeing of Aboriginal people and their communities. Swan and Raphael also outlined the association of past and contemporary losses (of land, language, Law, culture and kin) with the overwhelming trauma and grief and subsequent high rate of

mental health problems currently suffered by Aboriginal people. The *Ways Forward* report identified the need for service delivery to be based on a mental health promotion and prevention model, emphasising Aboriginal empowerment through self-determination, delivered according to local priorities in culturally sensitive ways. Key areas were prioritised, such as trauma and grief counselling, suicide prevention, programs to address family violence and substance abuse, with a particular focus on children, youth and families. The authors stressed the need to develop research and programs to urgently address the Aboriginal mental health crisis (Swan & Raphael).

A surge of research, reports and inquiries followed, aimed at understanding the prevalence and underlying risk factors in Aboriginal mental health disorders and social and emotional problems from a more holistic perspective. High rates of depression, suicide, family violence, trauma, grief, alcohol misuse, socioeconomic disadvantage and welfare dependence were identified (Atkinson, 1990a, 1990b, 2002; Hunter 1990, 1993; McKendrick et al., 1990; McKendrick, Cutter, Mackenzie & Chui, 1992). Hunter (1993) researched and conceptualised high risk behaviours such as suicide, homicide, violence, and alcohol misuse evident in remote WA and Queensland Aboriginal communities, using a socio-historical framework. *The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children* (1995-1997) heard more than 500 testimonies from Aboriginal people affected by the forcible removal of Aboriginal children from their families through government protection and assimilation policies, now termed the "Stolen Generations" (1910-1970). *The Bringing Them Home Report* highlighted the harrowing impact of past removal and institutionalisation of Aboriginal children on

the mental health and wellbeing of Aboriginal people, their families and communities (Human Rights and Equal Opportunity Commission [HREOC], 1997).

The report, *Putting the Picture Together* (2002) from *The Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in (WA) Aboriginal Communities* (*The Gordon Inquiry*) adds further detail to understanding the complex inter-relationship of past and current risk factors involved in family violence and child abuse in WA Aboriginal communities (Gordon, Hallahan & Henry, 2002). Most recently, *The Western Australian Aboriginal Child Health Survey* (WAACHS), a large scale epidemiological study has contributed to an improved understanding of the prevalence and aetiology of health and social and emotional problems in WA Aboriginal children and youth. The study linked past removal and institutionalisation of caregivers to increased risk of social and emotional problems in Aboriginal children giving systematic evidence for the impact of intergenerational effects (Zubrick et al., 2005). Ted Wilkes, chairperson of the WAACHS Steering Committee, stated on the release of the findings: "What this report quantifies is the level of suffering faced by too many Aboriginal young people – a burden that affects their long-term social and emotional development" (Wilkes, 2005).

Many Aboriginal people still live in adverse circumstances with a high rate of mental ill-health and suffering experienced by individuals, families and communities. However, some Aboriginal children have gone on to reach their full potential and Aboriginal people along with their cultures, families and communities have survived. Only recently has research centred on those factors which protect Aboriginal

youngsters from developing more serious problems such as depression, anxiety, suicidal behaviour and low self-esteem (e.g., Blair, Zubrick & Cox, 2005; Westerman, 2003; Zubrick et al., 2005). Research has suggested that building resilience factors such as connection to family, community and culture has a positive impact on individual and collective identity, self-esteem and overall wellbeing (Clark, Harnett, Atkinson & Shochet, 1999). Pearson (2000) asserted that increasing opportunities for empowerment (e.g., control, access to skills, resources, participation in decision making), increases autonomy, responsibility, self-efficacy and the overall mental health and wellbeing of Aboriginal people. Research into protective factors is scarce. For intervention to be targeted appropriately, more research is needed to understand what constitutes resilience and strengths in young Aboriginal people, families and communities.

There exists a growing understanding and evidence-base of Aboriginal mental health and social and emotional problems pertaining to young people, and many theories and methods on how to "fix" these problems. "Solutions" come from a wide range of multi-disciplinary sources, from governments to communities themselves. The *Evaluation of the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan* (2001) outlined many recent advances in policy development and mental health service delivery (Urbis, Keys & Young, 2001). However, the available research and inquiries still highlight the inadequacies of Aboriginal policy development and overall failure of services and programs to address the needs of Aboriginal people and communities. Brady (2004) stated that Aboriginal people have found mainstream services "alienating, disempowering and discriminatory" (p. 26). Submissions to *The Consultancy* in the early 1990s and

testimonies published in *The Bringing Them Home Report* (1997) highlighted the failure of mainstream Australia to fully understand and acknowledge Aboriginal culture and Aboriginal history, including the devastating impact of past atrocities like the Stolen Generations on Aboriginal mental health and wellbeing (HREOC, 1997; Swan & Raphael, 1995). Gordon et al. (2002) and other commentators (e.g., Eckermann et al., 2006; Neill, 2002; Pearson, 2000; Trudgen, 2000) explained how this lack of awareness and acknowledgment has contributed to a continued misunderstanding of Aboriginal people and their experiences, hence perpetuating racism, discrimination and further marginalisation of Aboriginal people. This has permeated the development of culturally insensitive policies, programs and services which have little relevance to Aboriginal people. As a result, mainstream mental health programs and services have been largely under-accessed by Aboriginal clientele (Vicary & Andrews, 2001) and are under-resourced, particularly in remote areas (Atkinson, Bridge & Gray, 1999). Furthermore, Brady (2004) highlighted the shortfalls of self-determination and self-management in Aboriginal service delivery. She explained how these policies encouraged a "hands-off" approach by non-Aboriginal policy-makers and service providers, that over time increased separatism, undermined collaboration and Aboriginal skills and resource facilitation, continuing to generate poor outcomes for Aboriginal people. Many services and programs have done little to ease the suffering and burden of mental ill-health and social and emotional problems in Aboriginal communities and in some cases have exacerbated the problems (Brady; Gordon et al.; Pearson).

Constructs such as Aboriginal empowerment, self-determination, control, participation, community development and capacity building all sound promising in

theory, but in many cases are yet to prove truly effective in practice (Neill, 2002). There are few efficacy studies of intervention approaches in Aboriginal communities. Evidence of best practice is coming from locally-driven approaches which respond to community need and have a contextual/Aboriginal understanding of the issues at hand. These approaches are holistic, show strong Aboriginal leadership and are prioritised, controlled and delivered by Aboriginal groups who work in trusting partnerships with non-Aboriginal agencies or government departments to seek required skills and resources. Impressive results have been seen in Cape York Far North Queensland, such as in Yarrabah Community where community-driven responses to suicide prevention over the last decade have seen a fall in the suicide rate (Mitchell, 2000). Cape York Partnerships (CYP) formed in 1999 is a community development initiative undertaking the enormous task of implementing broad socioeconomic change at all levels to achieve better health and wellbeing for Aboriginal people (Cape York Partnerships, n.d.). In terms of more equitable access to services, *The Gordon Inquiry* has resulted in some gains, influencing WA government departments and agencies dealing with Aboriginal family violence and child abuse to commit more funds for workers and resources on the ground in remote communities, although there is still critical need for increased resources (Department of Premier and Cabinet, 2002).

Progress has been made but there are currently many challenges at the societal and local levels, so there is no quick fix - longer term strategies are necessary (Trudgen, 2000). At a societal level changes are needed to clarify the misperceptions of the dominant culture about Aboriginal people and ultimately improve the way non-Aboriginal people work with Aboriginal people and communities. This includes

changing the socio-political structures and systems that prolong Aboriginal oppression, such as economic dependence on government welfare (Pearson, 2000). With the demise of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 2004 and reabsorption of ATSIC services and programs into the mainstream sector, Aboriginal communities face continued uncertainty. Noel Pearson (2000), while empathising with the plight of his people, calls all Aboriginal people to take responsibility for themselves and their families as a necessary means to improve the overall wellbeing of Aboriginal communities.

Ex Prime Minister John Howard, in the first ABC televised Press Club address for 2006, stated that his government "is willing to meet Aboriginal people more than half way" to combat welfare dependence, improve their economic situation and promote reconciliation amongst Indigenous and non-Indigenous Australians (Australian Broadcasting Corporation, 2006). The government's "whole-of-government" approach to service delivery in Aboriginal communities hinted at systemic change. The Coalition's controversial intervention rolled out in several Northern Territory (NT) Aboriginal communities in 2007 sparked by the *Little Children Are Sacred* report (Wild & Anderson, 2007) into the protection of Aboriginal children from sexual abuse, has been heavily criticised. The "NT intervention" (also termed Emergency Response) has been labelled discriminatory and criticised for taking a backward step to tight governmental control of Aboriginal people and communities (Calma, 2007). Despite this, a follow-up review of the NT intervention indicated that the intervention has made gains in health assessment of remote Aboriginal children. Furthermore, Aboriginal people in some NT communities have reported feeling safer due to alcohol restrictions and more policing

(Department of Families, Housing, Community Services and Indigenous Affairs, 2008).

2008 brings a change in government for Australia. The newly elected Rudd Labor Government put Indigenous affairs first on the parliamentary agenda by saying "sorry" to generations of Indigenous people "stolen" from their families as part of past government protection and assimilation policies. Hundreds of Indigenous people descended on Parliament House in Canberra and thousands listened elsewhere, for the formal apology many Aboriginal people had died waiting to hear. Prime Minister Rudd spoke, "the time has now come for the nation to turn a new page" (Rudd, 2008). It was a chance for Australians to acknowledge and to reflect. For Indigenous people to mourn, to celebrate and begin to heal. Symbolic as it was, it marked the time for all of us, Indigenous and non-Indigenous to look toward the future together, with hope. As James Baldwin (1924-1987), African-American civil rights novelist wrote:

> Not everything that is faced can be changed,
>
> but *nothing* can be changed until it is faced (Baldwin, n.d.).

This thesis is written by a non-Aboriginal person. It describes the concerns, ideas and experiences of West Kimberley Aboriginal and non-Aboriginal people as expressed to the author and project team, through many, many "yarns" over three years working in the West Kimberley on this research. It is hoped that the current knowledge on the mental health and social and emotional wellbeing of Aboriginal children and youth, particularly those young people living in remote communities

will be extended. It is also envisaged that people working with remote Aboriginal young people, families and communities will be able to incorporate the information contained in this thesis in their work, to help promote resilience and mental health in more culturally sensitive and practical ways for the long-term benefit of Aboriginal communities.

Overview of the Thesis

The first section of this thesis: Literature Review is covered in Chapters One to Four. Chapter One presents a brief history of the Kimberley region in WA, and the impact of this history on the mental health and social and emotional wellbeing of remote Aboriginal people and communities. This chapter also includes discussion of contemporary social influences and the impact of social disadvantage on youth wellbeing. Chapter Two presents a review of the research pertaining to the prevalence, aetiology, risk and protective factors associated with the mental health and social and emotional wellbeing of Aboriginal children and youth, with particular emphasis on young people living in remote areas. Problems having a significant impact on remote Aboriginal young people, such as alcohol and drug misuse, family violence, suicide and child abuse are discussed in more detail. The second part of the chapter provides a review of research and reports related to social and emotional resilience, and protective factors purported to enhance the wellbeing of Aboriginal children and youth.

Chapter Three reviews approaches to intervention for and with Aboriginal communities under the broad holistic conception of Aboriginal mental health and

wellbeing. The chapter presents core principles identified in the literature as necessary to include in frameworks for intervention in Aboriginal communities. Several approaches to intervention (e.g., mental health promotion, community development and whole-of-government approach) are also examined. Chapter Four concludes the literature review. In this chapter services and programs for improving the mental health and wellbeing of Aboriginal young people, families and communities are reviewed and outcomes reported where evidence is available.

Section Two: Methodology contains Chapters Five and Six. Chapter Five provides the rationale and theory for the methodology of the current research, drawing from qualitative research, Indigenous research, Community Psychology and ethical guidelines related to research with Aboriginal and Torres Strait Islander peoples and communities. Chapter Six details the methods and processes for the current research. The three phases of the research are described: (1) *Consultation to Collaboration*; (2) *Community Engagement in Interviews and Discussion Groups;* and (3) *Towards Community Action*. Study 1: Problems, Risk and Strengths; Study 2: Community Solutions; and Study 3: Feedback and Validation of the Research Findings are outlined in detail.

Section Three: Findings contains Chapters Seven to Ten. In Chapter Seven, the observations and reflections on the research process are discussed with particular reference to strategies for engaging and building capacity in Aboriginal people and agencies involved in this project. Chapter Eight presents the findings from Study 1: *Problems, Risk and Strengths* interviews and discussion groups. Study 1 results relate to research questions on understanding the mental health and wellbeing of remote

West Kimberley Aboriginal children and youth including: types of problems; signs and symptoms; risk and protective factors; coping strategies; and locally derived definitions of youth wellbeing and resilience. This chapter also provides a synthesis of the findings pertaining to Study 1, conceptualising the main problems impacting on remote young Aboriginal people. Problems include the breakdown of culture, alcohol and drug misuse, family fighting, lack of engagement in activities, and suicidal behaviour.

In Chapter Nine the findings from Study 2: *Community Solutions* discussion groups are discussed. These results detail ideas on community-based intervention activities and methods for intervention to promote mental health and wellbeing and build strengths in Aboriginal children and youth living in remote communities, particularly Ardyaloon Community at One Arm Point. The findings from Study 3: *Feedback and Validation of the Research Findings* are outlined in Chapter Ten. This chapter provides participant feedback on the validity of the findings from Study 1 and 2, as well as comments on the research approach and methods.

Section Four: Discussion and Recommendations contains Chapter Eleven. This final chapter includes review and comparison of the research findings with related literature. A model for community-based mental health promotion intervention with remote Aboriginal young people and communities is proposed based on the research findings and relevant literature. Chapter Eleven also includes discussion of the limitations of the current research and recommendations for future research and intervention to promote the wellbeing of remote Aboriginal youth and communities.

SECTION ONE:

LITERATURE REVIEW

CHAPTER ONE

HISTORICAL AND SOCIAL CONTEXT

This chapter presents a brief history of the Kimberley region, Western Australia (WA) including the impact of this history on the mental health and social and emotional wellbeing of remote Aboriginal people and communities. Following this is a discussion of the more recent social conditions experienced by remote Aboriginal people and the impact of social disadvantage on Aboriginal youth wellbeing. This chapter provides a historical, politcial and social context for understanding the mental health and social and emotional problems affecting Aboriginal young people and their families living in remote communities in the West Kimberley.

1.1 A Brief History of the Kimberley Region

Prior to European invasion traditional Aboriginal people were “natural farmers” with a complex understanding of the workings of the climate, land and sea (Trudgen, 2000). The vast waterways, rugged landmass, surrounding ocean and diverse flora and fauna of the Kimberley region provided Aboriginal people with drinking water, a rich diet, bush medicines, tools and shelter (Kimberley Aboriginal Medical Services Council [KAMSC], 2004). Aboriginal people had systems for economic independence, often trading with other groups, and systems of reciprocity, sharing food and resources with one another. Their livelihood, health, spirituality, identity and overall wellbeing were intrinsically linked to the land, ensuring land sustainability and their survival for over 60,000 years.

There were over 300 different tribal/clan groups across Australia, who spoke around 500 distinct dialects found nowhere else in the world. The Kimberley was home to 30,000 Aboriginal people from 50 distinct language groups (Kimberley Aboriginal Law and Culture Centre [KALACC], 1996). Clans were defined by language and geographic boundaries; they operated independently but were interrelated giving them both cultural-linguistic, spiritual diversity and a shared socio-cultural worldview (Bardi Elder now deceased, personal communication, December 2, 2003). Aboriginal people had a rich social tapestry, kinship, skin system and Law which delineated relationships, knowledge and education, social behaviour, care and responsibility amongst family members and clan groups (Trudgen, 2000). In Aboriginal society men and women had distinct but complementary roles with Elders ascribed sacred ceremonial rights. Ceremonies connected people with one another, their land and spirit (Berndt & Berndt, 1967). Children were attributed much freedom early in life; all members of the group nurtured and cared for the child. On reaching puberty, children learned and were a part of more complex social and spiritual aspects of culture essential in becoming an adult (Dudgeon, Garvey & Pickett, 2000). Aboriginal people creatively used songs, stories, dance and art for social, historical and spiritual purposes (Berndt & Berndt, 1980). Australian Aboriginal culture is one of the most complex, unique and oldest surviving cultures in the world.

Since colonisation Australian governments and their departments have enforced policies and practices of destruction and genocide (1788-1880s), segregation and protection (1890s-1950s), assimilation (1950s-1960s) and integration (1967-1972). They have attempted to bring about self-determination (1972-1975) and self-

management (1975-1996) and more recently reconciliation and economic rationalism (1996-present) (Centre for Aboriginal Studies Curtin University of Technology, 2001; Eckermann et al., 2006). Milroy (2005) stated:

> Western Australia has a history of racially based policies and legislation entrenched in a denial of the fundamental humanity and human rights of Aboriginal people (cited in Zubrick et al., 2005, p. 17).

Europeans settled Australia with the notion of *terra nullius*, that the land was not occupied by people with settled laws, the land was "no-one's land", thus denying Aboriginal existence and rights from first contact (Raphael & Swan, 1997). With little knowledge of Aboriginal Law and culture and no appreciation for it, Europeans granted themselves absolute ownership of land and rulership of the country. Aboriginal people had little protection under British colonial law and were subjected to massacres, land violation and cultural genocide (Bourke & Cox, 1994). The Kimberley was one of the last fertile regions of Australia to be colonised. Despite fierce resistance by traditional Aboriginal people, it soon became covered with government issued pastoral leases and imposed sheep and cattle stations including new townships created to support "White" occupation. Jails were created where thousands of Aboriginal people were incarcerated. To secure their survival many Aboriginal people worked for pastoralists and for much of the last century remained unpaid (KALACC, 1996). Aboriginal pastoral workers who remained on their traditional land continued to practise their culture. Aboriginal women who were domestic servants on stations connected with non-Aboriginal men; this gave rise to a new generation of "mixed descent" children. The Kimberley was also influenced by

the pearling trade from the 1860s. Large numbers of Aboriginal men were taken as "slave labour" to work on pearl luggers and women were used as prostitutes (Elkin, 1980).

In the northwest coastal areas where the pastoral industry was not established, the government in collaboration with church missions set out to institutionalise Kimberley Aboriginal people (KALACC, 1996). Under protectionist policies which served to control Aboriginal people "for their own good", the WA 1905 Aborigines Protection Act granted legal guardianship to the Chief Protector of all Aboriginal children under the age of 16 years. Family and community life was severely restricted. Aboriginal people were forced from their lands and placed in reserves (camps) and missions. Children were forcibly removed from their parents. Rights to marriage, parenting, education, employment, land ownership and freedom of movement in and out of reserves, missions and country towns was controlled by "protectors", often local policemen (Human Rights and Equal Opportunity Commission [HREOC], 1997).

The introduction of assimilation policies (1930s) within the protection era replaced the "passive merging" of Aboriginal people into non-Aboriginal society with a highly regulated assimilation process aimed at "civilising" and absorbing Aboriginal people into the dominant culture (HREOC, 1997; Swan & Raphael, 1995). The 1936 Native Administration Act increased suppression and control of Aboriginal people, particularly the legalised abduction of Aboriginal children from their families (Hunter, 1995). With changes to child welfare legislation in the 1950s, children were no longer removed based on skin colour, rather if they were found to be "neglected",

"destitute" or "uncontrollable". Families had few material possessions, little money and means to find work, thus they were increasingly vulnerable to removal practices. The social and emotional nurturance given by Aboriginal families was overlooked (Hunter, 1993).

From 1910 to 1970 between 10 and 30% of Aboriginal children were forcibly removed from their families, now known as the "Stolen Generations" (HREOC, 1997). Hunter (1993) reported that out of 600 Aboriginal people surveyed in the Kimberley from 1987 to 1989, 1 in 4 older people and 1 in 7 middle-aged people had been removed as children. In the West Kimberley, missions were set up northwest of Broome at Beagle Bay (1890). Children living in and around Broome were sent to Beagle Bay. Often their families followed but were separated from their children on the missions where children lived in separate dormitories or adults resided in surrounding camps (HREOC). Lombadina (1911-1985) and La Grange (Bidyadanga: 1955-1982) missions followed. An independent mission was set up on Sunday Island in 1899 and incorporated into the United Aborigines Mission in 1923 (Hunter). Many mixed descent Aboriginal children from the Kimberley were sent hundreds of kilometres away from their families, north to Moola Bulla near Fitzroy Crossing or south to Moore River and Sister Kate's mission settlements near Perth. During this time many children were also fostered out to non-Aboriginal families (HREOC).

The level of control varied amongst missions and institutions from some to no acceptance of Aboriginal culture (Hunter, 1993). Cultural practices such as use of language, Law and ceremonies were often forbidden and punishable (D. Appleby, personal communication, June, 2003). Children received consistent negative

messages about their Aboriginality (Swan & Raphael, 1995). Young people were told that their parents and families did not want them and some were even told their family members were dead. Some youngsters were subjected to harsh physical and psychological punishment, such as beatings and solitary confinement (HREOC, 1997). *The Bringing Them Home Report* revealed that 19% of institutionalised inquiry witnesses experienced physical abuse. The WA Aboriginal Legal Service submission to the inquiry stated that out of 483 children removed, almost two-thirds (62.1%) reported physical abuse, most often occurring at missions, and 13.3% experienced sexual abuse. One in 10 boys and 3 in 10 girls alleged they were sexually abused in foster care. Children received little emotional and physical attention. Some young people were punished for seeking help, particularly in relation to sexual abuse allegations. Schools were set up on missions where children were educated in religion, domestic duties and farm skills and sent out to work in their early teens (HREOC). Paul Sampi (Bardi Elder and Lawman) spoke of growing up at Lombadina mission:

> It was really hard. We would only see our parents on certain days at certain times. The rest of the time we stayed in dormitories while our parents lived on camp. We were reared by the German priest. We couldn't practise our Law – it was against Catholic rules for us to go through the Law (cited in KALAAC, 1996, p. 53).

For decades a system of oppressive paternalism involving pastoralists, missions, the Native Welfare Department (Chief Protector) and police maintained stringent control over Kimberley Aboriginal people, denying them participation in mainstream life

(KALACC, 1996). The 1944 Natives (Citizenship Rights) Act aroused mixed emotion for Aboriginal people. Those willing to live in complete accordance with White society, adopting a "civilised" lifestyle were given citizenship on condition they did not associate with Aboriginal people who did not have citizenship. This proved difficult and divisive for families (Aboriginal Affairs Department, n.d.). Kimberley Aboriginal people referred to the citizenship certificate as a "dog tag" (J. Roe, personal communication, November, 2003). The Aboriginal rights movement highlighted the injustices suffered by Aboriginal people which influenced the overwhelming "yes" vote in the 1967 Referendum. This paved the way for Aboriginal people to be included in the Australian census, and granted citizenship and voting rights (Bourke & Cox, 1994). However, for Kimberley Aboriginal people, voting in local government elections was restricted until 1984 (KAMSC, 2004). Post referendum, the Commonwealth Government was given the power to legislate on Aboriginal affairs, despite this the injustices toward Aboriginal people continued (Bourke & Cox).

For Kimberley Aboriginal people continued social upheaval occurred between the mid 1960s and the end of the 1970s with the withdrawal of imposed structures such as stations and missions (Hunter, 1993). KALACC (1996) reported that missions closed at the same time pastoralists disqualified Aboriginal people from employment and station land. Changes to pastoral technology and "equal" pay conditions granted to Aboriginal workers meant stations couldn't sustain Aboriginal employment. Large numbers of Aboriginal people moved to towns. This loss of employment coincided with provision of government welfare payments followed by legalised access to public bars and alcohol by 1971. In 1962 the Sunday Island Mission closed down and

the Bardi people were displaced to the Native Welfare Reserve on the outskirts of Derby (Crawford, 1989). By the 1970s many Aboriginal people had become refugees living on the fringes of towns in dire social and economic circumstances, consumed by cultural dispossession, unemployment, alcoholism, despair and hopelessness (Hunter, 1993; Pearson, 2000).

The election of the Whitlam Labor Government in 1972 saw a total repeal of the Native Welfare Act and a political and practical shift from assimilation towards self-determination. The Department of Native Welfare was abolished. Aboriginal people had the means to legally challenge removal of children and the welfare department stressed the need to keep children with their families, resulting in a massive decline in the number of children removed to non-Aboriginal care by the 1980s. Currently, children removed by the State for reasons of abuse and neglect are placed in Aboriginal care (HREOC, 1997). By the 1980s all missions in the Kimberley had handed control to local agencies such as the Department of Aboriginal Affairs.

Bardi leaders began to see the destructive effects of the fringe dwelling lifestyle on their people and endeavoured to reconnect them with their traditional culture and country. By 1971 they returned to the Dampier Peninsula north of Broome to set up a new community at One Arm Point (Hunter, 1993). Families initially camped on the beach, hunting, fishing and living in tune with their traditional lifestyle (I. Davey, personal communication, June, 2003). In 1973 the government gave the community funds to build infrastructure such as a school, store, clinic and powerhouse. In the late 1970s, many community men were employed in construction or collecting trochus shells at One Arm Point (West Australian Social Science Education

Consortium, n.d.). In accordance with self-management practices, community councils and administrations were set up with non-Aboriginal people employed in administration positions to "advise" Aboriginal council members on community management (Trudgen, 2000).

The result of self-determination for the Kimberley was that the oppressive assimilation system had been replaced with a flood of government agencies and transient non-Aboriginal government workers. Housing, health, education, employment and social welfare programs were moved into State run agencies and departments (Aboriginal Affairs Department, n.d.). KALACC (1996) reported that Kimberley Aboriginal people have never accepted the intrusion of government bureaucracy as it is "not accountable to the Aboriginal community and does not act in accordance with our rights and aspirations" (p. 49). Despite increased funds, many government run agencies failed to address the problems in Aboriginal communities due largely to lack of direction, lack of collaboration with Aboriginal groups, culturally inappropriate programs and services, and lack of resources on the ground (NAHSWP, 1989). Through self-determination practices Aboriginal people were afforded the means to set up their own organisations to address their own needs. With government funding administered through the Department of Aboriginal Affairs, the Broome Regional Aboriginal Medical Service (BRAMS) was founded in 1978, the first Aboriginal community-controlled health service in the Kimberley. This was followed by the Kimberley Aboriginal Medical Services Council (KAMSC) in 1986 which is still the primary health care resource body for the several remote Aboriginal Community Controlled Health Services (ACCHSs) in the Kimberley region (KAMSC, 2004).

Despite major steps forward through community-controlled services, Hunter (1990) stated that the opportunities promised as part of self-determination were only attainable by a few. Many Aboriginal people still had unequal access compared to their non-Aboriginal counterparts to the necessary means to take advantage of these opportunities, namely, resources, language, literacy, training and vocational skills. With few work opportunities and those available filled by "more skilled" non-Aboriginal people, many families and whole communities became entrenched in welfare dependence. Openly oppressive policies had been replaced, however, discriminatory attitudes and practices toward Aboriginal people continued. Hopes for socioeconomic justice were short-lived (Trudgen, 2000).

The Department of Aboriginal Affairs was abolished and replaced with the Aboriginal and Torres Strait Islander Commission (ATSIC) which commenced in 1990 as the main Commonwealth agency responsible for Aboriginal affairs. Several regional councils were formed; representatives were elected by the local community and were responsible for deciding how program funds were spent. The ATSIC Board of Commissioners was responsible for developing Aboriginal policies and programs and advising the Federal Government on Aboriginal affairs. ATSIC gave Aboriginal groups the means to have a say in running their own programs whilst making bilateral agreements with State and Federal Government departments. This along with the Native Title movement, the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC) and improved reconciliation processes, gave Aboriginal people a more powerful political voice and steps towards self-determination were made. However, ATSIC came under enormous scrutiny and suffered criticism both within and outside Aboriginal groups. The expectation was that ATSIC would "fix" all

Aboriginal problems, however with inadequate and misappropriated resources this expectation was unfulfilled (ATSIC, 1998).

The Community Development Employment Projects (CDEP) began in 1977 when Aboriginal leaders recognised their people were becoming entrenched in welfare dependence. With money from the Federal Government, administered by ATSIC (now Indigenous Coordinating Centres), CDEP funds a range of community-based programs where Aboriginal people work and earn the equivalent of unemployment benefits. The aim of CDEP was to develop communities while providing opportunities for training as a step into paid employment. CDEP accounts for about one quarter of Aboriginal "employment" and is often the only vocational option available to Aboriginal people in remote communities where paid jobs are scarce and mostly filled by non-Aboriginal workers (ATSIC, 1998).

The 1992 Native Title Mabo decision relinquished *terra nullius* and legally recognised Aboriginal people as traditional owners of the land (Bourke & Cox, 1994). KALACC (1996) argued that the land rights struggle in WA has been particularly difficult for Aboriginal people with hostile campaigns by the mining industry and State Government. In spite of this there have been recent claims awarded. For example, in November 2005, after a lengthy campaign, the Bardi and Djawi people received recognition of their Native Title rights to the northern end of the Dampier Peninsula in the Kimberley. However, this equated to only part of their claim. Native Title rights include the right to utilise the land and sea for hunting, fishing and ceremonial purposes (Office of Native Title, 2005).

Under the Howard Government (1996-2008) a new era of “economic rationalism” in relation to Aboriginal affairs ensued. On the release of the findings of the inquiry into the Stolen Generations (HREOC, 1997) the government was reluctant to accept the real impact of the past. Despite the formation of the Council for Reconciliation, the government was unable to apologise for past atrocities, although they promised improvements in health, housing, education and employment through “practical reconciliation”. Native Title appeared increasingly limited under the government’s “Ten-Point Plan” which safeguards pastoral leases. The start of the millennium has seen the disbandment of ATSIC and its service delivery arm the Aboriginal and Torres Strait Islander Services in 2004, with programs and services amalgamated into mainstream government departments and agencies (Calma, 2004; Eckermann et al., 2006). Eckermann et al. argued that without ATSIC, the elected voice of Aboriginal people has been silenced. New policies and practices encompassing “mutual obligation” and “shared responsibility agreements” were launched by the Coalition Government. This approach to service provision in Aboriginal communities has been criticised by Collard et al. (2005) who argued that the policy development lacked full input from Aboriginal people and that the approach is paternalistic and may undermine community autonomy, a necessary ingredient needed to improve the wellbeing of Aboriginal people.

Overall, there have been advancements in education and vocation, home ownership, health, land rights and steps towards reconciliation. However, the Aboriginal community still carries the burden of poor outcomes across most areas of living. Understanding the impact of historical policies and practices on Aboriginal people

past and present is key to conceptualising the mental health and wellbeing of Aboriginal young people, their families and communities (Trudgen, 2000).

1.2 The Impact of History on Aboriginal Mental Health and Wellbeing

Initial invasion, colonisation and the discriminatory government policies and practices that followed involved the systematic destruction of Aboriginal society which has had a debilitating and lasting impact on Aboriginal people and their communities, socially, economically, physically, psychologically and spiritually (Memmott, Stacy, Chambers & Keys, 2001). Swan and Raphael (1995) summarised the impact of historical practices on Aboriginal people: loss of recognition of human status (by *terra nullius*); loss of land; loss of hunting grounds and hence starvation; social fragmentation, war; loss of good health; enforced relocations into missions and reserves; loss of freedom; loss of cultural and legal norms; loss of citizenship; loss of control over their lives and environment; and forced removal of children (p. 16). Many argue that the culmination of these experiences is directly related to the high rates of mental ill-health and dysfunction evident in Aboriginal families and communities today (Trudgen, 2000).

Forced relocation and dispossession of Aboriginal land and kin occurred from invasion. Atkinson (2002) explained how land and family are the essence of Aboriginal identity and wellbeing, "being human is defined by the value given to *where we have come from*, *who we are*, and *where we are going* in relationship to country and kin" (p. 30). Without land Aboriginal people lost their means for sustaining good physical and spiritual health. Much of the traditional culture of

Aboriginal people residing at Beagle Bay and Lombadina missions was altered due to over 40 years of contact with pearling, pastoral industries and missions (Elkin, 1980). Aboriginal languages were lost at an alarming rate in some areas. Zubrick et al. (2005) reported 20% loss of language in remote and moderately remote areas of WA and increased loss in urban areas.

Aboriginal societal Law and leadership were broken down. Elders were disempowered; their systems for law, order, knowledge and education transfer were destroyed and replaced with non-Aboriginal political, legal and education systems. Trudgen (2000) argued that self-determination practices further undermined these traditional systems. Outsiders made decisions regarding Aboriginal affairs with little knowledge or consideration of Aboriginal history and culture. “White structures” such as community councils implemented in remote communities in the 1970s and 1980s replaced Aboriginal methods for decision making and law enforcement. Non-Aboriginal people found it easier to negotiate with younger Aboriginal people instead of Elders due to language and cultural differences, further marginalising Elders from decision making and destroying the respect given to Elders by younger generations. Loss of traditional systems, disempowered leaders/Elders, imposed structures and a clash of worldviews has given rise to confusion in community leadership, governance and management. Trudgen explains how this type of confusion is expressed as apathy and anarchy resulting in helplessness, poor leadership and governance, lawlessness and lack of overall control seen in Aboriginal communities. Pearson (2003) highlighted that the formal imposed systems of governance have undermined traditional Aboriginal values and structures, but the formal systems have not adequately replaced traditional governing structures

and processes. Aboriginal Law and wellbeing can not be separated, and collapse of Law has serious impact on individual and collective wellbeing (Atkinson, 2002).

The most devastating destruction of Aboriginal society occurred throughout the Stolen Generations. The Western Australian Aboriginal Child Health Survey (WAACHS: Zubrick et al., 2005) identified that over one third (35%) of Aboriginal children in WA are living in homes where their parent, carer or grandparent have histories of forced separation from their natural families and 24% from their traditional country, the Broome region having the highest proportion of removals in WA. The impact of these practices on family life has been irreparable. O'Shane (1995) explained, "families were torn apart, members being scattered around the country at the will of authorities who had no regard for the fact that Aborigines had family relationships" (p. 26). Systems for fostering relationships, respect, responsibility and child care, social learning and modelling were lost or replaced. Child and adolescent development and identity formation were strongly influenced by mission experiences. Many children raised in institutions and foster care received negative messages about their Aboriginality with little means to form an integrated identity. Aboriginal people left missions having had inadequate models for parenting, leaving many with difficulties raising their own children. HREOC (1997) argued, "most forcibly removed children were denied the experience of being parented or at least cared for by a person to whom they were attached. This is the very experience people rely on to become effective and successful parents themselves" (p. 222).

Swan and Fagan (1991) reported that abuses suffered during institutionalisation were found to have impaired children's ability to learn social and life skills which

contributed to difficulty functioning in essential areas of living. This later resulted in low educational achievement, unemployment and poverty, as well as emotional distress which resulted in violence against self and others, and the use of alcohol and substances to cope with this trauma. Victims of removal reported that negative images about their Aboriginality and families resulted in feelings of rejection, loss of individual and cultural identity, loss of a sense of belonging and safety in the world, isolation, alienation and lack of self-worth. Children removed prior to age 5 experienced disrupted attachment relationships which impeded their development, relationship formation, trust and sense of safety in their environment. Overall, people with histories of removal had increased risk for developing mental health and wellbeing problems (HREOC, 1997; Raphael & Swan, 1997).

Hunter (1993) reported that Kimberley Aboriginal families experienced continued if not worse social decline when missions were closed. Men lost employment on pastoral stations, bans on alcohol were lifted and people were granted welfare payments which became hugely debilitating for Aboriginal men and subsequently families. Many traditional male cultural roles were lost or interrupted as a result of dispossession. Some men gained a transitory role working on stations, and were often prided on their bush skills and handling stock. Hunter (1990) argued that loss of this role in the context of few employment opportunities resulted in the decline of men's self-esteem and self-worth. Men assumed the "socially accepted" role of the "drinker", often consuming alcohol to excess. Women became economically independent due to child welfare which shifted the power differential in favour of women, while further undermining male identity and self-esteem (Hunter, 1993). The children of this dispossessed and demoralised generation grew up in environments of

poverty, welfare dependence, familial alcoholism, violence, abuse, lack of guidance, hopelessness, and marginalisation from wider society. Hunter (1991e; 1995) believes that once these children reached adulthood the combined destructive impact of their upbringing was exhibited in violent and self-destructive behaviours enacted by this group. For example, in the last 20 years in the Kimberley there has been a marked increase in self-destructive behaviours such as motor vehicle accidents, followed by a dramatic increase in suicide and deliberate self-harm, homicides and family violence, most notably in young adult men.

In summary, the detrimental consequence of Aboriginal history stretches across Aboriginal individuals, families and communities. Dispossession and oppression of Aboriginal people through past government policies and practices resulted in poor physical and mental health (Swan & Raphael, 1995). This included family and community fragmentation; disintegration of leadership and governance; interruption of the transfer of knowledge, values and skills (e.g., parenting skills); disturbances in identity formation; education difficulties and unemployment; poverty and welfare dependence; violence, alcoholism and suicide; chronic feelings of diminished self-worth, helplessness and hopelessness and a perceived inability to control one's destiny (Atkinson, 2002; Hunter, 1993, 1995; Swan & Fagan, 1991; Trudgen, 2000). Trudgen argued that such denigration of self, culture, family and community is felt and expressed as an overall "crisis in living" (p. 59) for many Aboriginal people. In order to further understand the development of mental health and social and emotional problems in Aboriginal people it is essential to reflect upon the combination of this historical impact and how it has manufactured and perpetuated itself in the contemporary Aboriginal experience (Dudgeon, 2000a).

1.3 Contemporary Social Context and its Impact

While history was ultimately responsible for the predicament of many Aboriginal people, Pearson advocates that this alone could not account for the "social collapse" seen in Aboriginal communities since the 1970s (cited in Neill, 2002, p. 51).

1.3.1 Social Disadvantage

The deplorable level of social and economic disadvantage in Aboriginal communities, especially those in remote areas, has been a topic of discussion since protectionist policies, however it wasn't until the *National Aboriginal Health Strategy* (NAHS: 1989) and the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC: 1991) that the link between social disadvantage and ill-health in Aboriginal communities was prioritised (Hunter, 1993). Aboriginal people remain disadvantaged across a range of social and economic areas compared with other Australians. On average Aboriginal people die 17 years earlier than other Australians and unemployment rates are estimated at 13% compared with 4.6% for the general population. Aboriginal children and youth are over-represented in the juvenile justice system (Trewin & Madden, 2005). Overall, Aboriginal people experience poorer health, lower incomes, lower educational attainment, are less likely to own their own homes and more likely to live in overcrowded conditions when compared with other Australians (Trewin & Madden).

1.3.1.1 Employment and Economic Circumstances

Aboriginal people first lost their economic independence when forcibly removed from their land. Throughout the era of protection and assimilation they depended on

the dominant culture for food and clothing, and with the introduction of child welfare and unemployment benefits for family income (Hunter, 1993). Continued lack of employment and training opportunities for Aboriginal people has contributed to increased dependence on welfare with little means to break the cycle. Pearson (2000) stated that "passive welfare" is now endemic in Aboriginal communities and is responsible for the collapse of cultural, family, community and individual responsibility in Aboriginal society. He explained that the welfare system goes against Aboriginal notions of reciprocity and Aboriginal people have been encouraged to accept "something for nothing" (Pearson, 2003). Pearson (2000) views welfare as a method of governance which attributes power and responsibility to those in superior positions, rendering those in receipt of welfare passive and powerless. The "welfare mentality" becomes internalised so that people believe it is their right to receive assistance without reciprocation and this becomes entrenched in the next generation. Hunter (1995) and Trudgen (2000) argued that dependence paralleled with lack of opportunity leads to loss of mastery and hopelessness thus facilitating future dependence. This results in destructive behaviours such as neglect of responsibilities, drug and alcohol abuse and inflicting harm on self and others (e.g., family violence, homicide, child abuse and suicide). Pearson (2000) blames welfarism for destruction of Aboriginal cultural values and identity. He argued that the emergence of these problems coincided with welfare becoming the economic basis of Aboriginal society three decades ago. When Aboriginal people were granted citizenship in 1967, they were also granted welfare rights. Pearson explained that the biggest mistake was taking Aboriginal people out of the "real economy" working on cattle stations and giving them welfare. He points out that now there is very little engagement of Aboriginal people and communities in the real/mainstream economy.

Community enterprises are dependent on government provisioning, without which they would collapse.

Aboriginal people are more than twice as likely to be unemployed than their non-Aboriginal counterparts (Trewin & Madden, 2005). Eckermann et al. (2006) reported 40 to 100% unemployment in remote Aboriginal communities. ATSIC (1998) predicted that unemployment would increase by 2006 due to the small number of jobs available, especially in remote areas. In remote communities most Aboriginal young people are signed on to work for CDEP, receiving the equivalent of unemployment benefits (ATSIC). CDEP is often poorly managed and many people receive payments regardless of hours worked. With few actual paid jobs in remote communities, and the majority of those filled by non-Aboriginal people (e.g., shop manager, teachers, clinic nurse) many young people see no future beyond CDEP (KAMSC, 1999). Atkinson, Bridge and Gray (1999) argued that CDEP is an inadequate option for employment and training for Aboriginal young people. Lack of employment for prolonged periods has been associated with poor self-esteem and the development of high risk behaviours such as crime, violence, alcohol and drug abuse, suicide and mental health disorders (Hunter, 1993).

Gordon et al. (2002) reported that gambling was raised as a significant issue in Aboriginal communities where loss of income from gambling meant essential items (e.g., food, clothing) were not being purchased for children. Hunter (1993) stated that money lost gambling increases dependence and poverty. Moreover, money spent on alcohol leaves consumers without funds to buy household essentials, which in turn puts pressure on families and communities (Hunter). Many Aboriginal families

surveyed in the WAACHS experienced financial hardship. For example, 44% did not have enough money to see them through to their next payday and only 5% were able to save on a consistent basis (Blair, Zubrick & Cox, 2005). Atkinson et al. (1999) highlighted that essential items are expensive in remote communities and with Kimberley Aboriginal people earning below $200 per week, escaping poverty and leading a "healthy" lifestyle is extremely difficult.

1.3.1.2 Education

ATSIC (1998) stated that less than a third of Aboriginal youth finish secondary school compared with 70% of non-Aboriginal students. Aboriginal people overall account for only 1% of higher education admissions (Trewin & Madden, 2005). Educational outcomes for Kimberley Aboriginal children continue to be the worst in the State with only four students obtaining tertiary admission over the past three years (Atkinson et al., 1999). Despite recent employment of Aboriginal Educational Liaison Officers (AELOs) and some gains in educational outcomes for Aboriginal people, such as increased attendance at secondary and tertiary education, school retention is still a problem, especially in remote communities (Neill, 2002). Trewin and Madden stated that poor nutrition and chronic ear infections also contribute to low educational outcomes. Poor school attendance is linked to higher illiteracy, decreased skills, reduced access to higher education and employment opportunities, reduced access to social supports, greater difficulty navigating through mainstream life, and further marginalisation from mainstream society, all of which have a severe impact on the wellbeing of young Aboriginal people (Hunter, 1993).

1.3.1.3 Housing and Infrastructure

Many remote Aboriginal people live in community housing that does not support good health and wellbeing (Trewin & Madden, 2005). Atkinson et al. (1999) noted that there are substantial deficiencies in infrastructure, housing, water, power and recreational facilities in remote Aboriginal communities in the Kimberley. Many Aboriginal families who rent houses from community housing providers live in overcrowded conditions (Trewin & Madden).

1.3.2 Racism, Discrimination and Marginalisation

Aboriginal society has experienced extreme overt forms of racism and discrimination as part of its colonial history. In more recent times racism and discrimination have been more covert, harboured in institutionalised racism (e.g., legal, educational, vocational systems), leaving young people further marginalised from mainstream society (Sanson et al., 1997). O'Shane (1995) recounts her own childhood, hearing the comments of adults, including teachers who spoke of Aboriginal people as being "sly, no-good, dishonest, untrustworthy and lazy" (p. 27). Gordon et al. (2002) asserted that "racism attacks individual self-esteem and in turn community wellbeing" (p. 63). Discrimination is manifested in Aboriginal people having less access to opportunities and less ability to seize opportunities when they do arise, leaving them marginalised from mainstream life. Aboriginal people experience discrimination in schools, at work, on the television and have a real sense that they are excluded from the domains of economic and political power (Pearson, 2000). Racism and discrimination are recognised as significant factors associated with mental health and wellbeing problems in Aboriginal children and youth (Gordon et al.).

Berry (2005) stated that acculturation is the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members. At the group level, it involves changes in social structures and institutions as well as changes to cultural practices. At the individual level, it involves changes in the person's behaviour. Aboriginal young people trying to live in two cultures experience varying levels of distress during interactions with the dominant culture. Berry termed this "acculturative stress" which arises from problems with the acculturation process, particularly when Aboriginal people are required to meet the demands of the dominant group. Being marginalised (either within one's own culture or from the mainstream culture) is the most stressful acculturative experience. Marginalisation has been associated with alcohol and substance abuse, violence and suicide in young Aboriginal people (Hunter & Milroy, 2006)

In conclusion, the historical and social context has shaped the development of mental health and social and emotional problems in Aboriginal children and youth. The negative impact of history on contemporary Aboriginal society is undeniable, however current issues such as the combined effects of welfare dependence and poverty, poor educational attainment and unemployment, racism, discrimination and marginalisation experienced by young people and their families continues to make children and youth, particularly those living remote, vulnerable to further problems.

CHAPTER TWO

MENTAL HEALTH AND SOCIAL AND EMOTIONAL PROBLEMS IN ABORIGINAL CHILDREN AND YOUTH

Chapter Two presents a review of the research pertaining to the prevalence, aetiology, risk and protective factors associated with the mental health and social and emotional wellbeing of Aboriginal children and youth. The review examines the interplay of unique historical, social, political and cultural risk factors that place young Aboriginal people at increased risk of experiencing mental health and wellbeing problems. Pertinent problems impacting on young people, such as alcohol and drug misuse, family violence, suicide and child abuse are examined in more detail. In the second part of this chapter the concept of social and emotional resilience is discussed. This is followed by a review of the research and reports related to resilience and protective factors found to promote the wellbeing of Aboriginal children and youth.

2.1 Prevalence

The rate of reported mental health problems in Aboriginal people has ranged from 8 to 51%. Kyaw (1993) conducted a review of the available early epidemiological studies indicating that mental health problems in Aboriginal children ranged from 1.8 to 31.7% and 35 to 51% in adolescents. Prevalence rates from early studies vary due to different theoretical and methodological perspectives used.

Nurcombe and Cawte (1967) developed categories of childhood disorder based on behaviour which caused concern to parents and the dominant society, identified earlier in Sherwin and Shoelly's (1965) research with non-Aboriginal children (cited in Nurcombe & Cawte). A list of common symptoms was given to non-Aboriginal staff and Aboriginal community leaders to identify children with behavioural and emotional problems. Parents of children identified by this procedure were interviewed by the visiting psychiatrist and mission staff supplied information on family background. They found 36% of 280 children aged 2 to 14 years evidenced behaviour disturbance (e.g., conduct problems, aggressive and impulsive behaviour). Furthermore, 19% of children in this study showed anxiety-inhibition (e.g., shy, withdrawing behaviours) and 39% evidenced educational problems.

Kidson and Jones (1968) surveyed 208 children (aged 16 years or less) from the Warburton Range Mission, Western Desert, with Aboriginal and non-Aboriginal informants utilised to identify "abnormal", "unusual" and criminal behaviour in children. Behaviour was then categorised by the research psychiatrist into what was deemed a psychiatric disorder. Hospital records were checked and interviews were also conducted with the child. Three percent of children evidenced psychiatric disorder with no reported suicidal behaviours or anxiety disorders. The diagnosis of "behaviour disorder of childhood" was used to define severe behaviour problems however few children met this diagnosis. Using similar methods to their first study, Jones (1972) surveyed 147 Aboriginal children residing at Jigalong and Fitzroy Crossing mission settlements. Overall, psychiatric morbidity in remote Aboriginal children and youth was significantly less than that reported in mainstream society and in Nurcombe and Cawte's (1967) study (Jones; Kidson & Jones).

Gault, Krupinski and Stoller (1970a) conducted psychosocial interviews with 112 Victorian Aboriginal adolescents aged 12 to 21 years. Interviews were unstructured, covering the adolescent's attitude to school, work and health. Additional information was obtained from school principals, employers and mission staff. Information was recorded on a structured questionnaire from which psychosocial problems were identified by the researchers. Diagnostic categories were based on World Health Organisation international classification of diseases and included psychoneurotic disorders, juvenile crime and antisocial behaviour, social maladjustment (not working, not studying) and other psychiatric diagnoses (e.g., epilepsy). Results showed Aboriginal youth had high rates of delinquency and antisocial behaviour (20.9%) and social maladjustment (18%). Overall, 51.2% of those surveyed suffered from mental health and social problems which were shown to increase with age. Gault, Krupinski and Stoller (1970b) replicated their Victorian study with 81 Aboriginal adolescents and 42 non-Aboriginal adolescents aged 14 to 20 years living in Derby, WA. Aboriginal adolescents evidenced 17% juvenile crime and antisocial behaviour, and 9% social maladjustment; delinquency, antisocial behaviour or social maladjustment was not reported among non-Aboriginal youth. Derby Aboriginal families were found to experience high levels of poverty, family conflict, physical and mental ill-health, death, separation, alcoholism and crime compared to non-Aboriginal families.

Webber (1980) created a registry of mental ill-health in Aboriginal children living in remote Northern Territory "settlements" over an 8-year period visiting every 6 months. Psychiatric assessment included a standardised interview, observation and cross-cultural testing (e.g., Queensland Test for cognitive testing). Results showed a

greater number of male than female cases registered, males comprising around 70% of behaviour problems, “mental retardation”, and learning difficulties. Webber concluded that schooling presented difficulties for these children due to a “clash of values” and contributed to the high rates of cognitive and learning problems (p. 122).

Early studies reported high but variable rates of education and learning difficulties, behaviour disorders and social adjustment problems in young Aboriginal people across remote and urban settings. Remote Aboriginal children and youth were found to have significantly higher rates of conduct problems, social maladjustment and family dysfunction than non-Aboriginal youngsters residing in the same area (Eastwell, 1985; Gault, Krupinski & Stoller, 1970b). Webber (1980) reported that males experienced behaviour and learning problems with greater frequency than female children. Suicidal behaviours and internalising problems in Aboriginal children and youth were not reported in early studies, perhaps indicative of the limited knowledge of general child psychopathology at the time. The limitations of theory and methodology incorporated in early studies, such as an overall bias toward Western constructs and methods, use of largely non-Aboriginal informants to depict problems, varied and non-(culturally) validated classification systems of disorder and small sample sizes, contributed to an incomplete account of the prevalence and extent of problems in Aboriginal youngsters (Kyaw, 1993). Therefore, from these studies it is difficult to provide an accurate report of the mental health and social and emotional problems in Aboriginal young people or to compare results from early studies with mainstream and overseas studies (Kidson & Jones, 1968; Kyaw; Hunter & Garvey, 1998; Swan & Raphael, 1995; Webber).

The 1990s saw a major change in the way Aboriginal mental health was perceived, conceptualised and subsequently researched. The influence of social, historical and political issues on Aboriginal mental health and wellbeing was increasingly acknowledged (Johnson, 1991; National Aboriginal Health Strategy Working Party [NAHSWP], 1989). *Ways Forward* (Swan & Raphael, 1995) redefined Aboriginal mental health from an Aboriginal rather than non-Aboriginal perspective, taking into account contextual determinants and a broader notion of mental health. Swan and Raphael outlined that:

> any delineation of mental health problems and disorders must encompass a recognition of the historical and socio-political context of Aboriginal mental health including the impact of colonisation; trauma, loss, and grief; separation of families and children; the taking away of land; the loss of culture and identity; plus the impact of social inequity, stigma, racism and ongoing losses (p. 2).

In *Ways Forward*, Swan and Raphael (1995) reported widespread trauma and grief in Aboriginal communities, with anecdotal reports that depression, suicidal behaviour, alcohol and substance misuse, child abuse, social disadvantage and economic inequity were prevalent at much higher rates than in non-Aboriginal communities.

A relative outpouring of more collaborative investigations and inquiries followed (Raphael & Swan, 1997). These studies and inquiries extended early studies by encapsulating the broader holistic conception of Aboriginal mental health and wellbeing, incorporating socio-historic, political and cultural determinants into their

investigation of mental health problems in Aboriginal populations. McKendrick et al. (1990) reported a high rate of psychological distress in Aboriginal communities, expressed as depression, anxiety and substance abuse. McKendrick, Cutter, Mackenzie and Chiu (1992) assessed psychiatric morbidity amongst 112 urban Aboriginal people presenting to the Victorian Aboriginal Health Service. Sixty-seven percent of respondents were aged 15 to 29 years. Interview questionnaires were piloted with Aboriginal Health Workers (AHWs) to assess the acceptability and cultural sensitivity of questions. Results showed that 54% of urban Aboriginal people displayed psychiatric disorders as defined by an Index of Definition of 5 or more on the Present State Examination. This was significantly higher than non-Aboriginal people presenting to general practices. Up to one third were found to have an identifiable mental illness. Of these, 82% had a diagnosis of depression, the most common mental health problem recorded in this population (McKendrick et al.).

The Western Australian Aboriginal Child Health Survey (WAACHS: Zubrick et al., 2005) conducted from mid 2000 to mid 2002 surveyed the prevalence, risk and protective factors pertaining to the mental and physical health of 5289 WA Aboriginal children under the age of 18 years. The survey used a wide range of carer and youth self-report measures including the Strengths and Difficulties Questionnaire (SDQ: Goodman, 2001), cross-referenced with health and medical records. Where applicable results were compared with non-Aboriginal children surveyed in the 1993 Western Australian Child Health Survey (Zubrick et al., 1995). Results showed 26% of Aboriginal children aged 4 to 11 years were at high risk of clinically significant emotional and behavioural difficulties compared with 17% of non-Aboriginal children in this age group. Twenty-one percent of Aboriginal youth aged 12 to 17

years showed high risk for emotional and behavioural problems compared with 13% of non-Aboriginal youth (Zubrick et al., 2005). Blair, Zubrick and Cox (2005) reported that 31.4% of Aboriginal youth had clinically significant conduct problems compared with 13.1% of non-Aboriginal young people. Overall, Blair et al. reported that social and emotional problems occurred at higher rates in Aboriginal than non-Aboriginal younsters.

Ralph, Hamaguchi and Murray (2003) surveyed 368 Aboriginal youth (average age 15 years), 76 adults (average age 35 years) and 303 non-Aboriginal people (283 youth, 20 adults) living across the Kimberley region. The study utilised mainstream psychological measures adapted for use with Kimberley Aboriginal people to investigate the prevalence and impact of trauma on depression, anxiety, posttraumatic stress disorder (PTSD), suicidal behaviour and substance misuse. The study also aimed to understand issues such as identity, self-esteem, anger, "shame", and how these impact on the development of psychological disorders in Aboriginal youth. Results indicated that 11.5% of Aboriginal respondents evidenced symptoms of PTSD, 30.6% mild to severe depression, 22% general anxiety and 17% showed clinically significant suicidal ideation. Results for youth alone were not reported. Aboriginal participants reported feeling more hopeless, had lower self-esteem, used more negative coping skills, felt more anger, shame and less control over their lives than their non-Aboriginal counterparts.

Kyaw (1993) argued that mental health problems such as anxiety and PTSD have been poorly recognised in past studies. Sheldon (2005) reasoned that non-Aboriginal people are less able to identify such problems in Aboriginal people. The impact of

trauma on mental health is a rapidly advancing field of research, although still under-researched in the general population and Aboriginal people. Available reports suggest some evidence for PTSD in Aboriginal populations. For example, submissions from psychiatrists in *The Bringing Them Home Report* identified that Aboriginal clients referred for psychiatric assessment met the diagnosis for PTSD (Human Rights and Equal Opportunity Commission [HREOC], 1997). Ralph et al. (2003) hypothesised that Kimberley Aboriginal youth experiencing high levels of distress and suicidal ideation may meet the diagnosis of PTSD.

Herman (1997) was the first to formulate the diagnosis of complex PTSD in adults suffering repeated traumatising experiences. She found that the diagnosis of PTSD failed to adequately capture a full understanding of the experience of multiple trauma. Terr (1994) studied PTSD in relation to children and found two types of syndromes she labelled Type I, which results from a single traumatic event and Type II, which manifests after repeated traumas. Clinicians commonly refer to these disorders as simple and complex PTSD, respectively. Stien and Kendell (2004) detail prevalence and symptomatology of simple PTSD and complex PTSD in relation to non-Aboriginal children. Given the high rates of trauma and distress reported in the literature, it is possible some Aboriginal young people would meet diagnoses associated with trauma symptomatology (e.g., PTSD, complex PTSD), however more research is needed in this area.

The prevalence of mental health disorders in children and adolescents in the general population is increasing (Zubrick, Silburn, Burton & Blair, 2000). It is difficult to compare prevalence rates from studies of Aboriginal youngsters with non-Aboriginal

young people due to the varying methods used. However, Zubrick et al. (2005) found that social and emotional problems reported in the WAACHS were significantly higher in Aboriginal children and youth when compared to non-Aboriginal young people. With a focus on Aboriginal holistic notions of mental health and wellbeing, more recent studies have extended earlier research, by improving methodology and evidencing a broader range of mental health and social and emotional problems in Aboriginal children and youth, such as depression, anxiety and suicidal behaviour.

2.2 Risk Factors

Young Aboriginal people are at greater risk of developing mental health disorders and experiencing social and emotional problems than their non-Aboriginal counterparts, with unique socio-cultural, political and historical factors exacerbating this risk. The available literature suggests that mental ill-health in Aboriginal children and youth has multiple causal and risk factors (Zubrick et al., 2005). Risk factors are those which contribute to the development of mental health and wellbeing problems or intensify existing problems. There are predisposing (underlying) risk factors that foster a vulnerability to a particular problem; more immediate precipitating factors and those factors that serve to maintain existing problems (perpetuating factors). Risk factors are interrelated and exist at individual, family, community and societal levels and they may vary according to the population under investigation, affecting individuals and communities in differing ways across time (Graham et al., 2000). Rutter (1993) cautioned that it is necessary to focus on risk processes rather than individual risk factors. Risk processes explain the interplay of risk factors. Correct conceptualisation of risk can also aid in effective intervention

and prevention of mental health and social and emotional problems in young people (Zubrick et al., 1996). Riley and Masten (2005) outlined pertinent contextual and inherent risk factors identified for non-Aboriginal children such as socioeconomic status, unsafe communities, parenting quality, low birth weight and genetic factors. Little research has been done to determine the inter-relationship of risk factors which contribute to and maintain mental health and social and emotional problems in Aboriginal children and youth. A review of all risk factors for all mental health and wellbeing problems in young Aboriginal people is beyond the scope of this thesis. However, the available literature related to pertinent problems experienced by Aboriginal children and youth is detailed below.

Gault, Krupinski and Stoller (1970b) reported that psychosocial problems were evident in 35% of Aboriginal adolescents living in Derby, WA. The authors noted that rapid social change and poverty were strongly related to increased prevalence of juvenile crime and antisocial behaviour in remote Aboriginal adolescents. Social factors such as low income and poor housing conditions were shown to relate to higher prevalence of psychosocial problems. McKendrick et al. (1992) reported the association between social and economic disadvantage and increased rates of mental health and wellbeing problems such as depression, substance abuse and suicide in predominantly young urban Aboriginal people. Social and economic adversity has also been shown to be a risk factor for people from non-Aboriginal backgrounds. For example, Sawyer et al. (2000) reported that young people from low income families were at greater risk of having mental health problems. However, Rutter (1993) suggests that just raising the standard of living in a community will not necessarily reduce the rate of mental ill-health in that community. Therefore, it is important to

investigate how risk factors in combination operate and impact on mental health problems in young Aboriginal people.

The 1991 *NSW Aboriginal Mental Health Report* (Swan & Fagan) outlined multiple risk factors associated with mental ill-health in Aboriginal people, for example, racism and discrimination, poverty, alcoholism, continued lack of employment and educational opportunities, cultural difference in values and expectations, family separations, high rates of chronic illness and early mortality. Research with non-Aboriginal youngsters has found social and familial factors such as low socioeconomic status, family conflict, child abuse and neglect, parental mental health disorder, substance abuse and social isolation may hinder a child's development and increase their risk of developing mental health problems such as depression (Cicchetti & Toth, 1998; Raphael, 2000). Individual risk factors for internalising problems include pessimistic explanatory style, lack of social skills and poor problem solving skills, and poor peer relationships (Cicchetti & Toth; Roberts, 1999).

The WAACHS examined child, carer, familial and societal risk factors related to social and emotional problems in Aboriginal young people aged 4 to 17 years (Zubrick et al., 2005). Zubrick et al. reported that the most significant individual factors related to high risk of clinically significant emotional and behavioural difficulties in children aged 4 to 11 years were: being male, having speech difficulties, and physical health problems. For youths aged 12 to 17 years, the risk factors were: being female, having low self-esteem, experiencing racism, drinking to excess, using marijuana and lack of physical activity.

Zubrick et al. (2005) reported that maternal or carer factors most likely to contribute to increased social and emotional problems in Aboriginal young people were: use of alcohol and or tobacco during pregnancy, mental and physical health problems and forced childhood separation from parents. Family factors included: overuse of alcohol causing problems at home, living in five or more homes since birth, poor family functioning (e.g., lack of emotional support, family cooperation), parenting skills difficulties (e.g., physical discipline, little use of praise), multiple stressful or traumatic life events and living in a sole parent family or with extended family members.

Risk factors associated with poorer outcomes in non-Aboriginal children such as carer education level, carer access to social support and financial strain were not found to be significantly related to increased social and emotional problems in Aboriginal children. Additionally, low participation in cultural activities and gambling, theorised in the literature to be high risk factors, were also not significant. Zubrick et al. (2005) explained how other factors are moderating the risk of these factors to reduce their overall impact. For example, higher carer education and income are moderated by the effect of life stressors, poor family functioning and poor carer health. Families are being overwhelmed by stressful life events, having a detrimental impact on the mental health and wellbeing of Aboriginal young people and their families.

Kamien (1978) was one of the first to speculate on the experience of historical practices such as parental separation and its association with Aboriginal mental health problems. In their study of urban Victorian Aboriginal people, McKendrick et

al. (1992) found that 49% of people interviewed had been separated from their families prior to 14 years, 20% had been brought up in institutions, and 10% by a non-Aboriginal family. They concluded that poor psychological outcomes (e.g., depression, suicide, substance abuse) related to separations and living with non-Aboriginal caregivers. Swan and Fagan (1991) reported that over 25% of Aboriginal people presenting to an urban Aboriginal Medical Service in Redfern Sydney, were diagnosed with mental health problems such as depression, anxiety, unresolved trauma and grief, PTSD, substance abuse, suicidal and antisocial behaviour which also increased their risk of incarceration. These people had a childhood history of separation from parents. *The Bringing Them Home Report* (HREOC, 1997) gave anecdotal evidence that the impact of past separation and institutionalisation of Aboriginal people, including abuses suffered during this time, increased their risk of developing mental health problems such as: attachment and relationship difficulties; developmental delay; identity and personality disturbance; grief, multiple losses (e.g., culture, country, family); parenting difficulties; depression, general anxiety and PTSD; alcohol and drug misuse, violence; and poor coping skills (HREOC).

2.2.1 Stressful Life Events

Aboriginal families and communities experience a significantly higher number of stressful life events than non-Aboriginal people (Raphael & Swan, 1997). Research suggests that a greater number of stressors in day to day living contributes to increased mental health and social and social and emotional problems in young people (Rutter, 1993). Swan and Raphael (1995) reported that racism, discrimination, social adversity and inequity, frequent and repeated losses through high rates of early mortality experienced by Aboriginal people, comprise ongoing stressors which

results in increased mental health problems in this population. Ralph et al. (2003) found Kimberley Aboriginal adults and youth witnessed or experienced far more traumatic events (e.g., domestic violence and suicide in a family member) than their non-Aboriginal counterparts. Similarly, Blair et al. (2005) identified higher rates of stressful life events in WA Aboriginal children and youth compared to their non-Aboriginal peers (69.6% compared to 13.8%); major life stressors included illness or death of relatives, family break up, arrests, and coping with financial strain. Over 1 in 5 young Aboriginal people lived in a family which had experienced 7 or more significant stressful life events in the 12 months before the WAACHS study, compared with only 0.02% of non-Aboriginal children. Children whose primary carer reported 7 to 14 stressful life events were over five times more likely to be at high risk of emotional and behavioural problems compared to children living in families who had experienced fewer stressors (Zubrick et al., 2005).

2.2.2 Intergenerational Risk

Atkinson (2002) defined the phenomenon of *intergenerational trauma* as the experience of trauma passed down directly from one generation to the next; and *transgenerational trauma* as the experience of trauma transmitted across a number of generations (p. x). Transmission of this trauma occurs through narratives detailing traumatic experiences told to the next generation, and emotions and behaviours learned as a result of traumatic events and modelled to children. Without modification these effects are transported to the next generation further compounding the traumatic effects across individuals, families and whole communities. Gordon, Hallahan and Henry (2002) highlighted that Aboriginal spokespeople advocate that the current dysfunctional behaviour seen in Aboriginal communities is embedded in

unresolved grief and trauma from multiple traumatic events spanning several generations.

The mental health and wellbeing of young people is intrinsically related to the emotional and physical wellbeing of their parents and carers, thus risk for problems is often transmitted across generations when effective interventions are not available to break this cycle (Zubrick et al., 2005). Dodson (2003) spoke of violence "that is now so entrenched in our relationships that the victims become perpetrators of violent acts which continue to the next generation of children, so that even before those children reach adulthood, they in turn become perpetrators of violence against members of their own families" (p. 2), with very few Aboriginal families not struggling with the devastating impact of trauma from their experiences of violence.

The Bringing Them Home Report cited anecdotal evidence for intergenerational effects from the Stolen Generations, highlighting that many grandparents and parents affected by removal and institutionalisation had children with emotional and behavioural problems (HREOC, 1997). Zubrick et al. (2005) noted that until the WAACHS study there was little empirical evidence of the impact of removal on Aboriginal adult, child and youth mental health and no evidence for intergenerational effects. Results showed that parents and carers who were forcibly separated from their natural families were more likely to live in households with problems caused by overuse of alcohol or gambling; almost twice as likely to have been arrested or charged with an offence; less likely to have social supports; and more likely to have had contact with mental health services. The impact on their children included more than double the risk of clinically significant emotional or behaviour problems such as

conduct problems and hyperactivity, as well as higher levels of alcohol and other drug use in adolescents. With a lack of available effective and appropriate services and programs, and lack of support networks to address the underlying and maintaining risk factors for problems impacting on young Aboriginal people, the problems will continue to have a devastating affect on future generations (Memmott, Stacy, Chambers & Keys, 2001).

The following chapter section provides the prevalence and risk factors related to the most commonly identified and debilitating problems impacting on young Aboriginal people, families and communities. All are problems in their own right and contribute significantly to the development and maintenance of mental health disorders and social and emotional problems in Aboriginal children and youth. A discussion of all risk factors pertaining to the following problems in Aboriginal young people is beyond the scope of this thesis (for further information see Gordon et al., 2002; Hunter, 1993; Hunter & Milroy, 2006; Memmott et al., 2001; Wild & Anderson, 2007). The problems detailed below have been separated out for ease of discussion, however it must be noted that understanding problems in Aboriginal contexts requires integration of problems, their antecedents and impact on individual, family and community wellbeing.

2.3 Alcohol and Drug Misuse

2.3.1 Prevalence

Aboriginal alcohol consumption and substance use (e.g., tobacco, cannabis) is reportedly high and disproportionate compared to the general population

(McKendrick et al., 1992). Hunter, Hall and Spargo (1992) identified that 76% of males and 46% of females from a sample of 516 Aboriginal people in the Kimberley consumed alcohol at substantially high levels. For young males this equated to approximately 11 cans of full strength beer in a 24 hour period. Hunter et al. reported that 94% of Aboriginal people consuming alcohol did so at harmful levels to health and wellbeing. This result is similar to other studies that have shown fewer Aboriginal people than non-Aboriginal people drink alcohol but a higher proportion of those who do drink alcohol do so at harmful levels (Hunter, 1992a). Hunter et al. reported that heavy drinking is most common in young adult men. Blair et al. (2005) reported that alcohol use in Aboriginal children and youth involved in the WAACHS did not differ significantly from non-Aboriginal youngsters, although a larger number of Aboriginal young people reported poly substance misuse, using alcohol, tobacco and cannabis with a significant negative impact on health, mental health and wellbeing.

2.3.2 Risk

Alcohol misuse and dependence have been associated with the development and maintenance of mental health disorders in Aboriginal people such as depression, PTSD, psychosis, and social and emotional problems such as socioeconomic disadvantage, family violence, homicide, suicidal behaviour, self-harm, child abuse and incarceration (Atkinson, 1990a, 2002; Gordon et al., 2002; Hall, Hunter & Spargo, 1993; Hunter, 1990, 1993, 1995; Hunter et al., 1992; Memmott et al., 2001). More recently, WAACHS results demonstrated that Aboriginal youth who used alcohol, tobacco and cannabis were at high risk of physical and mental health problems (Blair et al., 2005). Hunter et al. (1992) highlighted that alcohol itself does

not *cause* mental ill-health or social and emotional problems, however interspersed with other factors alcohol and drug misuse can contribute to and exacerbate these problems.

Hunter (1990, 1993) explained that in relation to Kimberley Aboriginal people, increased access to alcohol in the 1970s coincided with sustained increase in deaths by external causes such as accidents in the mid 1970s, and violence, specifically self-harming behaviours, suicide and homicide from the 1980s. Hunter (1990) and Reser (1991) noted that alcohol operating in the context of other factors (e.g., unemployment) contributed to this increase. Hunter (1993) found anxiety and depression (as defined by the Hopkins Symptom Checklist-25 [HSCL-25] which generates current symptoms of depression and anxiety) highest among young adults who were identified as constant drinkers (those consuming alcohol almost every day of the week). Hunter reported that psychotic symptoms, self-harm and suicidal ideation also increased significantly with increased alcohol consumption. Constant drinkers were 13 times more likely to have practised self-mutilation than non-drinkers. In addition, there was found to be a strong relationship between frequency of drinking, the amount consumed and rates of incarceration. Hunter found that, of males under 50 years who drank alcohol, 92% indicated they had been detained in police custody in the year prior to the study, and incarceration was 183 times greater for heavy drinkers than non-drinkers. Alcohol misuse is symptomatic of a number of other risk factors such as dispossession, disempowerment, unemployment and welfare dependence and it also maintains these problems (Hunter; Trudgen, 2000).

Alcohol misuse also has maintenance effects on existing mental health problems such as depression, general anxiety and PTSD. Alcohol and other substances such as glue, petrol, cannabis, Valium, Serapax and amphetamines have been used by Aboriginal people as a coping strategy for relief from pain and suffering from past and current trauma (Atkinson, 2002; Reser, 1991). Pearson (2000) pointed out that Aboriginal "drinking circles" reinforce social and cultural relationships and obligations. Everyone is obliged to contribute resources to purchasing alcohol and obliged to share the alcohol. Hence, the drinking circle becomes a "suction hole" for the family's resources, with the traditional obligation to share resources being corrupted and now sustaining alcoholism in communities. Alcohol plays a role in destroying obligations toward looking after children and old people, as well as corrupting Aboriginal Law (e.g., "sly grog" selling, violence and an inability to look after family). Brady (2004) commented on other factors maintaining community alcohol misuse, for example how family members often support and protect drinkers, making allowances for them and providing them with resources. Brady explained that this is a "culturally appropriate" way of dealing with disruptive drinking so as not to show collective social disapproval or interference in other's lives. Bolger (1991) outlined that lack of endorsement and policing of policy such as "dry communities", sale of alcohol in communities (e.g., social clubs) and poor leadership and governance (e.g., council members who profit from alcohol sales) exacerbate the alcohol problem. Dudgeon (2000) points out the debilitating nature of alcohol abuse on mental heath and wellbeing, "prolonged states of addiction to alcohol and or other substances hinder individuals and groups from participating in actions towards their healing and empowerment" (p. 73).

2.4 Family Violence

2.4.1 Prevalence

Violence in Aboriginal communities usually refers to violence perpetrated in families (domestic violence) which can include physical, psychological, sexual, emotional, spiritual and economic abuse. Violence also includes intrapersonal (e.g., suicide and self-harm) and community or clan fighting (e.g., family feuding) as well as abuse and neglect of Elders (Bolger, 1991; Cheers et al., 2006; Gordon et al., 2002; Hunter, 1991e). Atkinson (1990a) also draws attention to cultural/spiritual violence enacted by the colonisers at invasion and thereafter, through abuse, murder, coercion and control. The term "family violence" is preferred by Aboriginal people to describe domestic and other forms of violence (Atkinson; Gordon et al.). Violence is a major problem for Aboriginal communities and is disproportionately higher than in non-Aboriginal communities. Rates of violence are increasing and the types of violent behaviours are worsening in some Aboriginal communities (Memmott et al., 2001). Most commonly women and children are victims of violence in Aboriginal communities (Bolger; Hunter). The true prevalence of Aboriginal family violence is unknown at this stage, although it was revealed that Aboriginal people living in rural and remote areas are 45 times more likely to be victims of family violence than non-Aboriginal people (Western Australia Police Service submission, cited in Gordon et al., p. 424). Trewin and Madden (2005) reported that in 2002 to 2003, one quarter (24%) of Aboriginal people were victims of physical or threatened violence. In Ralph et al.'s (2003) study, 65% of Aboriginal people in the Kimberley reported witnessing family violence compared with 49% of non-Aboriginal people in this area.

2.4.2 Risk

Family violence has been linked to increased emotional and behavioural problems in non-Aboriginal children such as anxiety, depression, aggressive behaviour and low self-esteem (Zubrick et al., 1996). Atkinson (1990b) reported that violence seriously impedes parenting competence, as a North Queensland Aboriginal woman pointed out, “if we are being bashed and raped we cannot look after our children properly. We don’t feel good enough about ourselves” (p. 12). In a study conceptualising family violence in Ceduna Aboriginal Community, South Australia (SA), Cheers et al. (2006) reported that participants believed violence diminished families and communities, specifically socio-cultural and emotional resilience. For example, violence eroded trust, cohesion, caring, respect, cultural traditions, control of children, Elder authority, and separated families from social supports such as school, employment and relatives. Many studies have cited the connection between violence and high incarceration, especially among young adult males (e.g., Atkinson, 1990b).

Memmott et al. (2001) explained that prior to colonisation most fighting in Aboriginal communities was structured and occurred in designated places monitored by Elders or senior adults, and was carried out in line with social rules in response to specified offences. The disempowerment of Elders by institutional practices (e.g., banning cultural practices, Law) and the subsequent breakdown of socio-cultural and political systems for law, order and conflict resolution in communities are underlying factors in Aboriginal violence (Atkinson, 1990a; Hunter 1991e; Memmott et al.; Trudgen, 2000). Hunter explained that where Aboriginal Law necessitates punishment for wrongdoing, this may occur in an unstructured manner and could be hazardous. Furthermore, the imposed structure of community living where several

families were placed together in close proximity, where they would usually have resided in smaller family groups, has contributed to unrest in some communities (Bolger, 1991; Hunter).

Hunter (1993) examined additional predisposing social and historical factors in Aboriginal violence in Kimberley Aboriginal communities. He conceptualised that through dispossession and imposed institutions Aboriginal men lost their cultural and transitory (e.g., station-hand) work roles and with this the means to provide for their families. Women kept their role through child bearing and attained economic independence through child welfare. This destroyed male identity, self-esteem and increased their reliance on women which heightened men's helplessness, hurt and rage. Young Aboriginal men are still unable to attain independence, autonomy and positive identity due to lack of work opportunities and reliance on welfare (Hunter, 1998b). Hunter hypothesised that violence perpetrated by men against self or others reflects their profound lack of self-esteem, violence against self signifying powerlessness, violence against women representing "displacement of rage from the perceived oppression of a dominant and excluding culture" (p. 193). Thus, violence serves as a means for expression of power and powerlessness (Hunter & Milroy, 2006). Atkinson (1990a, 1990b) and Bolger (1991) argued that women also lost their status and autonomy due to imposed "White" patriarchal values and structures which allowed increased male control both Aboriginal and non-Aboriginal. Dudgeon (2000) reiterates that Aboriginal people over the generations have been unable to safely act out anger and frustration towards non-Aboriginal oppression and have transferred this hurt and rage inward against themselves and onto those most

accessible - their own group. Therefore, historical, and social factors are strong underlying determinants of contemporary violence.

Alcohol and substance misuse have been reported as common precipitating factors in violence in Aboriginal families and communities (Atkinson, 2002; Bolger, 1991; Cheers et al., 2006; Hunter, 1990, 1991e, 1993). Furthermore, Memmott et al. (2001) stated that jealousy between males and females was one of the most significant precipitators of domestic violence. Financial hardship, unemployment, grief and loss, and the need to "pay" someone back for a past wrongdoing against a family member were also factors linked to the increased likelihood of violence in Aboriginal communities.

Those factors seen to maintain or perpetuate violence are attitudes around family violence, shame, fear and blame which encourage denial of the problem in communities (Swan & Raphael, 1995). Factors operating outside communities and in institutions (e.g., police), such as non-Aboriginal misperceptions about violence in Aboriginal communities, also contributes to lack of responsiveness to violence (Atkinson, 1990b). Swan and Raphael explained that people do not accept the violence but do not want to break their families up by sending their men to jail. "What has emerged in many contemporary Indigenous communities is a social climate of violence tolerance" (Memmott et al., 2001, p. 31). Gordon et al., (2002) concluded that lack of police presence in remote Aboriginal communities and mistrust of these and other government services, as well as community governance problems, means that violence goes unreported and remains unchanged.

2.5 Suicidal Behaviour

2.5.1 Prevalence

Hunter (1993) argued that suicide was virtually unknown or went unreported in Aboriginal populations prior to the 1970s. The WA Youth Suicide Advisory Committee (Hillman, Silburn, Zubrick & Nguyen, 2000) report into suicide between 1986 and 1997 indicated that suicide was the second most common cause of death in young Aboriginal males in WA. Disturbingly, reported rates of suicide in Aboriginal youth have ranged from 2 to 7 times the national average for this age group with some of the highest rates found in the Kimberley region (Hillman et al., 2000; Hunter, 1991c; Ralph et al., 2003). In 1998 in the Kimberley, on average one young male Aboriginal person took his own life each month (KAMSC, 1999). This is consistent with Hunter's (1990, 1991a, 1991c) report that in the Kimberley, self-destructive behaviours (e.g., suicide and self-harm) are increasing among Aboriginal youth, particularly males. The WAACHS identified that 9% of female and 4.1% of male adolescents had attempted suicide and over 1 in 6 (16%) had seriously thought about suicide in the 12 months prior to the survey (Zubrick et al., 2005). These rates are consistent with, if not higher than, those reported in international research on suicide in Indigenous communities. Suicide in Canadian Indigenous youth is over three times the national average (Chandler & Lalonde, 1998), and suicide rates in Maori populations in New Zealand are twice that of non-Indigenous groups (Lawson - Te Aho, 2004). Graham et al. (2000) noted that Aboriginal suicide often occurs in clusters known as "contagion" suicide, as seen in Far North Queensland communities, with one community experiencing nine suicide deaths in 24 months. Ralph et al. reported that 28% of Kimberley Aboriginal people surveyed had lost a

family member to suicide. Despite these alarming rates, Aboriginal suicide and self-harming behaviours are still under-reported (Westerman, 2003).

2.5.2 Risk

In the general population strong risk factors for adolescent suicide include: previous attempt(s); psychiatric diagnosis (e.g., depression, schizophrenia, personality disorder, conduct disorder); substance abuse; family dysfunction, discord, disruption; parental mental health disorder; family violence; physical and sexual abuse; exposure to suicidal behaviour in others; and socioeconomic hardship (Graham et al., 2000). In Aboriginal populations historical, political, social and cultural factors complicate this risk. Many studies and reports have conceptualised the risk factors involved in suicide in Aboriginal communities (see Hunter 1990, 1991c, 1993, 1998b; Hunter, Reser, Baird & Reser, 1999; Hunter & Milroy, 2006; Reser, 1991; Tatz, 2005). In a review of past studies Kyaw (1993) deduced that the most common precipitating factors for Aboriginal suicide include excessive alcohol use, family violence, relationship problems and the perception of being rejected by relatives, in combination with interpersonal factors, such as, shame, fear, sadness and hopelessness. In a review of the literature, Westerman and Vicary (2000) identified risk factors for suicide in Aboriginal youth including: the impact of past removal and dislocation; institutionalisation of parents, carers and intergenerational transmission of this impact to their children. They outlined that histories of alcohol misuse and mental health disorders (e.g., psychosis) were found in young people who completed suicide. The authors added that social isolation and disrupted cultural identity can exacerbate distress and bring about suicidal behaviour in young Aboriginal people.

Reser (1991) from his work in Far North Queensland communities identified a range of historical, cultural and interpersonal factors contributing to suicidal behaviour in young Aboriginal people. These included: marginalisation of families and individuals; identity and developmental problems; breakdown of social control and social supports; substance abuse; relocations and dislocation from land; and family history of institutionalisation.

From his study with Kimberley Aboriginal people, Hunter (1991c) reported that young males who had committed suicide had experienced mental health and social and emotional problems such as depression, psychotic symptoms, heavy alcohol use, and familial alcohol abuse, past suicide ideation and or attempts, precipitated by alcohol misuse at the time of suicide, and recent loss (e.g., conflict or separation from their partner). Alcohol was detected post mortem in over two thirds of suicide deaths by hanging in Queensland Aboriginal communities (Hunter et al., 1999). Hunter et al. reported that hanging as a method is predominant in Aboriginal suicides in remote communities. The authors theorised that hanging is a powerful symbol of injustice for Aboriginal people, a stark emblem of the *Royal Commission into Aboriginal Deaths in Custody*. Cultural/spiritual and community specific explanations of previous suicide deaths can also increase risk of further suicide. Aboriginal people are more likely to attribute problems like suicide to external causes. For example, grieved relatives in North Queensland Aboriginal communities have reported being beckoned by dead relatives or “evil” forces to suicide themselves. More recently, Hunter and Milroy (2006) raised potential neurobiological risk factors related to suicide in young Aboriginal people, such as the impact of trauma on child brain development and subsequent behaviour.

The *Choose Life* report (KAMSC, 1999) into Aboriginal youth suicide in the Kimberley surveyed young people's perceptions of the risk factors for Aboriginal youth suicide. Young people identified interpersonal factors such as hopelessness, distress, boredom and environmental factors such as lack of social supports, family and community violence, as well as sexual, physical, emotional abuse and neglect to be some of the main risk factors for suicide in young people. In a study in the remote northwest of WA, Westerman (2003) found family violence, cultural bullying, lack of affiliation with Aboriginal culture, relationship breakdown, poor coping skills and impulsivity to be some of the main risk factors for suicidal ideation in Aboriginal youth.

Mental illness such as depression has been found to be associated with increased risk of suicidal behaviour (for a review see Graham et al., 2000). The WA Youth Suicide Advisory Committee report showed that of the Aboriginal people who had been treated for mental illness, 40% males and 50% females were diagnosed with depression prior to suicide (Hillman et al., 2000). Studies with non-Aboriginal youth diagnosed with depression have shown that they are at increased risk of suicidal behaviours (e.g., Harrington et al., 1994; King et al., 1997). Harrington et al. estimated that up to a third of depressed children and adolescents may later attempt suicide in adulthood. Ralph et al. (2003) noted that Kimberley Aboriginal youth who experienced suicidal ideation also reported witnessing traumatic events and experiencing depressive symptoms. The authors suggested where depressive symptoms aren't dominant, PTSD may be related to suicidal behaviour.

Recent research has further validated the findings from previous studies. Zubrick et al. (2005) found that low self-esteem, exposure to family violence, being at risk for emotional and behavioural problems, using cannabis, drinking excessive amounts of alcohol, and having friends who had committed suicide increased a young Aboriginal person's vulnerability to suicidal behaviour.

2.6 Child Abuse and Neglect

2.6.1 Prevalence

Child abuse covers physical, verbal, sexual and emotional (psychological) abuse as well as neglect (Gordon et al., 2002). Memmott et al. (2001) adds "lack of effective parenting, withdrawal of support and love, domestic violence, failure to provide adequate medical care and cultural deprivation" (p. 49). The Kimberley Peninsula Women's Group (advocates against child abuse) stated that cultural and spiritual abuse also constitute abuse of young Aboriginal people (KAMSC, 2003).

In WA during 2000 to 2001, Aboriginal children were 7.6 times more likely to be the subject of substantiated child abuse cases and more likely to have been the subject of substantiated neglect than children from other cultural backgrounds (Aboriginal and Torres Strait Islander Commission [ATSIC] submission cited in Gordon et al., 2002). Trewin and Madden (2005) reported that WA Aboriginal children were over-represented in the child protection system by a ratio of 8:1. Aboriginal children are also more likely to suffer sexual abuse than non-Aboriginal children (Gordon et al.). Atkinson (1990b) estimated that over 80% of young Aboriginal women in the juvenile justice system were victims of sexual assault and just as many cases go

unreported. Memmott et al. (2001) in their investigation into violence in Aboriginal communities identified a growing number of cases of sexual assault on children under 10 years, and child sexual abuse perpetrated by youth. Overall, child abuse, specifically child sexual abuse is widespread and drastically under-reported, especially in remote Aboriginal communities where abuse is often perpetrated by relatives living in close proximity to the child (Wild & Anderson, 2007).

2.6.2 Risk

There is a paucity of research into the risk factors for child abuse in Aboriginal communities although it is accepted that multiple factors at individual, family, community and societal levels combine to increase a child's risk of abuse (see Telethon Institute for Child Health Research [TICHR] submission cited in Gordon et al., 2002, p. 55 for a summary of risk factors linked to sexual aggression and violence in non-Aboriginal populations). Child abuse is an example of violence thus many risk factors discussed above also relate here.

In the past, abuse of Aboriginal children and youth was perpetrated by non-Aboriginal people in positions of power and authority in missions, institutions and foster placements. However, child abuse is now most often perpetrated by a male family member (Ford, 2000). In a recent government commissioned inquiry into sexual abuse in Northern Territory Aboriginal communities, Wild and Anderson (2007) reported that some perpetrators of child sexual abuse were juveniles. Many of these young people were also victims of sexual abuse. Ford (2000) asserted that intra-familial child sexual abuse is on the increase, or disclosures are increasing.

Wild and Anderson reported that some female Aboriginal youth were found to be exploited and abused via “organised” sexual offending, such as prostitution.

Aboriginal people advocate strongly that child abuse is not a part of Aboriginal culture (KAMSC, 2003). Recently, inquiries and reports have speculated on the underlying factors involved in Aboriginal child abuse. *The Gordon Inquiry* outlined how trauma related to dispossession and destruction of Aboriginal society, particularly through forced removal is intrinsically linked to the abuse seen in Aboriginal families and communities (Gordon et al., 2002). The interpersonal and societal impact of the Stolen Generations, including mental ill-health, loss of systems for child care (family dysfunction) and breakdown of value systems, law and order, have been implicated in contemporary abuse (HREOC, 1997). *The Bringing Them Home Report* identified how abuse suffered by families as a result of White oppression and abuse suffered by children abducted and institutionalised has directly contributed to difficulties in parenting the next generation of children and increased their risk of suffering abuse (HREOC). Gordon et al. also reviewed risk factors such as poor community governance, social disadvantage and welfare dependence, alcohol and substance abuse, gambling, and exposure to violent and sexually provocative images, as precipitating factors in child abuse in WA Aboriginal communities. Wild and Anderson (2007) found similar risk factors in Northern Territory Aboriginal communities. They concluded that the combined effects of poor health and housing, alcohol and drug abuse, poor education and unemployment, gambling, pornography, as well as an overriding loss of community identity and control contributed to sexual abuse of Aboriginal children and youth. Perpetrators were found to be victims of

childhood sexual abuse, thus continuing the cycle of sexual offending in communities.

Child abuse seriously interrupts a child's pathway to successful emotional, cognitive, social and sometimes physical development. A history of child sexual abuse is a risk factor for the development of mental health and wellbeing difficulties in young people. These problems can include anxiety, depression, PTSD, personality disorders (e.g., Borderline), suicidal behaviour and self-harm, behaviour problems (e.g., offending), school difficulties, substance misuse, somatic complaints, sexually transmitted infections (STIs) and psychotic symptoms particularly following a sexual assault. A child experiencing sexual abuse is at greater risk of further abuse later in life (TICHR submission cited in Gordon et al., 2002). Stien and Kendell (2004) reported that children with histories of maltreatment may meet the criteria for mental health disorders, including eating disorders, anxiety disorders, complex PTSD, attention-deficit hyperactivity disorder (ADHD), substance abuse, mood disorders, and dissociative disorders. The insidious nature of child abuse, particularly sexual abuse renders victims (and their families) hopeless and helpless, with profound feelings of shame, guilt and mistrust. *The Gordon Inquiry* (Gordon et al., 2002) and *Little Children Are Sacred Report* (Wild & Anderson, 2007) concluded that under-reporting and failure of government agencies to respond adequately further compounded risk for child abuse in remote Aboriginal communities.

In conclusion, anecdotal reports suggested extensive mental health problems in Aboriginal communities (Swan & Raphael, 1995). Subsequent studies and inquiries confirm that rates of mental health and social and emotional problems are high

among Aboriginal children and youth. Aboriginal young people are at far greater risk than their non-Aboriginal peers of experiencing more serious problems such as trauma, depression, suicidal behaviour, alcohol and substance misuse, family violence and child sexual abuse (Gordon et al., 2002; Hunter, 1993; Hunter & Milroy, 2006; McKendrick et al., 1990; Memmott et al., 2001; Wild & Anderson, 2007; Zubrick et al., 2005).

Much of the focus in Aboriginal mental health research has been on understanding problems in Aboriginal people and communities. More recently there has been a shift toward identifying strengths. The next part of this chapter examines some of the literature and research on social and emotional resilience in youngsters, and the available literature related to resilience and those factors which promote mental health and wellbeing in young Aboriginal people and communities.

2.7 Resilience

In a move away from deficit to strength-focused approaches, the field of child development research has increasingly looked toward the concept of resilience and what factors combine to produce good physical and mental health outcomes in children exposed to adversity (e.g., Werner, 1993). Resilience is the capacity of individuals, groups and systems, such as families and communities, to adapt and cope successfully in the face of adversity. Resilience is shaped by both internal and external factors and is considered to be context-specific, developing and changing across time and situations (Ford, 2005). Therefore, resilience is best understood as a pattern of adaptation, in terms of developmental processes and interacting individual-

environmental (e.g., family, school, community, society) systems (Riley & Masten, 2005).

In the construction of definitions and conceptualisations of Aboriginal mental health few studies have looked at the concept of resilience, especially in relation to young people. Rutter (1993) outlined that there is huge variation in how young people respond to life stressors and hardship, with some succumbing to mental ill-health, others showing resilience and a few even developing strength from adversity. Some young Aboriginal people cope better than others, even though they have to deal with the same sorts of problems. For example, not every young person who has experienced trauma has ongoing hopelessness, low self-esteem or mental health problems. It is important to know what it is about these young people, which enables them to cope well with life and bounce back from hard times. Given the holistic construction of Aboriginal mental health, it is necessary to examine historical, social, political, cultural, spiritual and emotional conditions that constitute resilience at all levels impacting on the child, such as the individual, family, community and society. Leadbeater, Dodgen and Solarz (2005) argued for the need to focus resilience research on the diversity of individual, family, and community responses to adverse circumstances and the strengths, competencies and resources across contexts required to deal with adversity.

2.8 Protective Factors

Resilience or protective factors provide a buffer against developing mental health problems and reduce the impact of existing problems by moderating the impact of

risk factors or reducing one's exposure to risk. Interventions that focus on building protective factors have important implications where risk factors can not be easily altered (Spence, 1996), a consideration which is pertinent to Aboriginal populations. Little is known about protective factors in non-Aboriginal children, even less so in Aboriginal children. As with risk factors one must look at the inter-relationship of protective factors not just independent factors, to assess what determines mental health and wellbeing in young people. Rutter (1993) explained that people respond differently to stress and adversity due to personal characteristics, previous and subsequent experience and coping styles, therefore, it is important to focus on the interplay between people and their experiences across contexts.

Rutter (1993) summarised the protective factors involved in mental health in non-Aboriginal children, including: parental supervision; positive peer influences; social problem-solving strategies along with confidence to carry them out; self-esteem derived from secure, supportive relationships/attachment; positive opportunities such as work, education; successful coping, and acceptance of negative experiences in place of denial or distortion. Werner (1993) conducted a large scale longitudinal study of multi-racial children born on Kauai, Hawaii in 1955 to assess a range of risk and protective factors. Participants were assessed at ages 1, 2, 10, 18, and 32. About a third of the children were exposed to perinatal stress, poverty and family problems (e.g., discord, alcoholism, mental illness). Those identified as resilient were "good natured" as infants eliciting positive responses in caregivers. They were more autonomous toddlers, formed strong peer relationships at school, had good reasoning and communication skills allowing these youngsters to engage well in activities which gave them a sense of competence and achievement. By adolescence they had

developed a positive self concept and internal locus of control. Protective factors at the familial level included close attachment with a primary caregiver, positive role models, supportive parenting including household structure and rules. Positive community influences for youth included participation in recreational activities, support from youth leaders or church ministers, and employment, training and educational opportunities, all enabling these young people to believe that their lives had meaning and they had control over their fate to make a healthy transition to adulthood. Werner (2005) stated that protective factors allowed young people to overcome adversity. For example, people who relied on support from families and the community increased their competencies and efficacy which decreased the number of stressful life events and presented new opportunities. In early caregiver relationships where attachments are secure, children learn how to relate to others, regulate their emotions and develop a positive sense of self which provides an important protective system to buffer adversity (Riley & Masten, 2005).

Rutter's (1993) research with non-Aboriginal children reared in institutions revealed that many felt at the mercy of fate and did not act to deal with life's challenges. He argued that resilience may be fostered in feeling in control of one's life and being effective in shaping responses to adversity, having a sense of mastery and control over one's experiences. Similarly, Syme's (1997) work in the field of health promotion identified that people who had less opportunity to influence the events that affect their life, or felt less control over their destiny, had poorer outcomes. Chandler and Lalonde (1998) and Chandler (2006) reported that community level factors such as self-government, Native Title, and increased local control over education, health, police and child protection services related to reduced suicide rates

in Canadian Aboriginal communities. Australian studies and reports have theorised that a sense of control and self-determination are necessary components to improved mental health and wellbeing in individuals, families and communities. The literature on risk for mental ill-health in Aboriginal populations has reported that lack of self-determination, powerlessness, lack of control, autonomy and independence to be some of the most debilitating risk factors for poor mental health outcomes and the development of problems like violence, suicide, alcohol and substance misuse (Hunter, 1993; Memmott et al., 2001).

Swan (1988) identified a number of protective factors needed to promote mental health in young Aboriginal people which were also supported by the *National Consultancy into Aboriginal and Torres Strait Islander Mental Health*, as follows:

> High self-esteem and self confidence
>
> Freedom to communicate needs and feelings
>
> The ability to love and be loved
>
> A sense of belonging to family and community
>
> Ability to cope with stress
>
> Being able to relate, create and to assert oneself
>
> Having options for change that help the development of a problem solving approach
>
> Being comfortable with your environment, and
>
> Believing in something (family, community, culture, religion)
>
> (cited in Swan & Raphael, 1995, p. 17).

Westerman and Vicary (2000) reviewed Aboriginal and mainstream literature to outline the protective factors involved in Aboriginal youth mental health. Individual factors included: individual temperament (positive outlook on life, desire to overcome adversity and do well); coping skills (problem-solving over emotion-focused coping); ability to shift between mainstream and culture of origin; having abilities, skills (e.g., sport); and strong sense of pride in culture. Family and community factors included attachment to a primary caregiver, positive role models and support from a peer group.

Van Uchelen, Davidson, Quressette, Brasfield and Demerais (1997) in a qualitative study with Canadian Aboriginal people, identified themes related to wellness and strengths which were perceived by people as providing a buffer against mental illness. These included sense of community (belonging), Aboriginal identity, practising cultural traditions, contribution to others, spirituality, interpersonal characteristics (e.g., self-respect, self-esteem) and coming through hard times. Some of these factors were also identified in McKendrick et al.'s (1992) study with urban Victorian Aboriginal people. Those who grew up with their Aboriginal family, learned their culture early in life and had links to their traditional country showed better mental health outcomes (e.g., less depression, substance misuse, suicidal behaviour) and less overall distress. Westerman (2003) surveyed 100 Aboriginal youths from the Perth metropolitan area and 103 from the northwest of WA (Karratha, Roebourne, and Port Hedland). She used a self-report assessment tool (Westerman Aboriginal Symptom Checklist – Youth [WASC-Y], Westerman, 2003) developed as part of the study to identify symptoms of anxiety, depression, suicidal ideation and low self-esteem as well as factors that protect Aboriginal youth from

these problems. The study found that Aboriginal youth in Karratha who showed less symptoms for depression, anxiety and suicidal ideation than youth in Port Hedland, identified that they spoke their traditional Aboriginal language, knew their tribal group, respected their culture, liked being Aboriginal "mostly" or "heaps" and had relationships with Aboriginal and non-Aboriginal peers equally. Port Hedland youth reported they knew less of their culture and traditional language, experienced higher levels of family violence and drug use, did not like being Aboriginal as much and viewed non-Aboriginal people as more racist.

McLennan and Khavarpour (2004) in a small study with Aboriginal people in a north-eastern NSW community found that culture and spirituality was crucial to Aboriginal wellbeing. For example, close family and kinship connections, spiritual affiliation with land and cultural practices related to positive identity for individuals and the community and enhanced wellbeing. In a study of violence in Ceduna Aboriginal Community SA, Cheers et al. (2006) reported that the community identified significant family, community and cultural strengths/protective factors, such as respect of Elders and their knowledge, participating in cultural activities (e.g., gathering bush tucker, family culture camps, art/craft) and leadership. The factors embedded in family, extended family networks, community and culture were viewed as providing positive identity, pride of place socially, purpose in life (e.g., responsibility for others) and overall protection from the negative impact of violence and related problems. These strengths were viewed as interdependent, for example, "strong families maintain strong culture while strong culture keeps families strong" (p. 57). Cheers et al. also explained that sport and recreation facilities in the community provide places where these strengths can be affirmed.

Blair et al. (2005) reported that the main objective of the WAACHS study was to identify developmental and environmental factors that promote positive physical, emotional, social and developmental outcomes in Aboriginal children aged 0 to 17 years. The authors reported that for Aboriginal adolescents living in "extremely remote" areas, their place of residence may be a protective factor against less optimal health and mental health outcomes. However, Brady (1993) explained that remoteness can be a risk factor for higher rates of death and injury from motor vehicle accidents, suicide and alcohol abuse, and poorer physical health. The WAACHS study also indicated that low levels of life stress, good family functioning and care of the child by parent(s) or an overall absence of risk factors for mental and physical disadvantage protected Aboriginal youngsters from social and emotional problems. Additionally, Aboriginal youth who were physically active had better self-esteem and fewer social and emotional problems. Zubrick et al. (2005) reported that maternal participation in cultural activities was not found to protect Aboriginal youngsters from developing social and emotional problems. However, the authors noted that additional risk factors, such as multiple stressors reduced the impact of some protective factors. A high household occupancy level was found to be a protective factor for young children (4 to 11 year olds). The WAACHS showed children with high household occupancy were half as likely to be at high risk of clinically significant emotional and behavioural problems than children with low household occupancy levels. However, overcrowding has been related to increased health and wellbeing problems in Aboriginal youngsters (Atkinson et al., 1999; Gordon et al., 2002). Zubrick et al. explained that more people in the household may equate to more help being available, increased flexibility in managing stress and may provide a buffer against other risk factors.

2.9 Summary

In summary, research and reports have highlighted underlying risk determinants (e.g., historical, social, political, cultural factors), perpetuating factors (e.g., alcohol problems) and maintenance factors (e.g., socioeconomic disadvantage; lack of autonomy and control; under-resourced and inadequate intervention). The literature indicates that protection against adversity and poor mental health and wellbeing for Aboriginal youngsters can be found in the individual (e.g., positive self-esteem, coping skills, cultural knowledge), families/friends (e.g., good systems of care, positivre role models) and communities (e.g., control, leadership, knowledge and practise of culture, recreation facilities). The available evidence suggests that risk and protective factors are multifaceted and interrelated, occurring across many levels (e.g., individual, familial, community, societal) and domains (e.g., socioeconomic, educational and vocational, cultural), that influence child development and subsequent psychosocial functioning. The interconnection of factors across these systems needs full consideration when conceptualising the mental health and wellbeing of Aboriginal children and youth (Maton, 2005). The focus must be holistic looking beyond the specific problem to locating problems and solutions amongst the wide range of contextually-embedded interlocking influences (Cheers et al., 2006). Consequently, promoting mental health and wellbeing in Aboriginal young people requires action across many areas of living.

The second part of the literature review contains a review of approaches to intervention in Aboriginal communities, including a review of services and programs

designed to promote resilience and enhance mental health and wellbeing in young Aboriginal people, families and communities.

CHAPTER THREE

INTERVENTION APPROACHES FOR PROMOTING ABORIGINAL MENTAL HEALTH AND WELLBEING

This chapter begins the second part of the literature review. Chapter Three presents a background to the development of mental health intervention for and with Aboriginal people and communities. A holistic framework for mental health intervention is then explained to illustrate the importance of positioning intervention efforts within the broader context of Aboriginal mental health and wellbeing. This chapter describes important principles idenitified in the literature to incorporate into intervention frameworks to promote the wellbeing of Aboriginal people and communities. This is followed with a review of approaches to intervention applicable to Aboriginal communities.

3.1 Background to Mental Health Intervention in Aboriginal Communities

Trudgen (2000) argued that in order to comprehend the shortcomings of any approach utilised in Aboriginal communities it is important to understand the developmental history of interventions. Only then can more appropriate solutions be found. At the turn of the 1990s Aboriginal people were still struggling to receive appropriate acute medical care, mental health was a grossly neglected area of inquiry and intervention (National Aboriginal Health Strategy Working Party [NAHSWP], 1989; Swan & Fagan, 1991). The *National Aboriginal Health Strategy* (NAHS) report evidenced a lack of Federal and State Government action and direction in

planning and implementing policy, services and programs to meet the needs of Aboriginal people (NAHSWP, 1989). Swan and Fagan in the *NSW Aboriginal Mental Health Report* found no effective mainstream mental health services for Aboriginal clientele, no cultural education programs for non-Aboriginal mental health workers, few Aboriginal people trained in mental health service provision, and under-funded and ill-equipped Aboriginal Medical Services (AMSs) attempting to deal with the high rate of mental ill-health amongst the Aboriginal community. *The National Consultancy on Aboriginal and Torres Strait Islander Mental Health (The Consultancy*: Swan & Raphael, 1995) highlighted these and further inadequacies to governments and the mainstream mental health sector. Swan and Raphael emphasised that the mainstream approach to Aboriginal mental health intervention failed to acknowledge, understand and incorporate Aboriginal history, culture and conceptions of health and healing. Services were deemed inappropriate and were under-utilised by Aboriginal people. Mental suffering in the Aboriginal population had largely gone unnoticed, undiagnosed and untreated with growing concern that inappropriate mainstream responses were making problems worse (Atkinson, 1990b; McKendrick et al., 1990; NAHSWP; Swan & Raphael). Pearson (2002) claimed:

> Despite the fact that ours is one of the most dysfunctional societies in the world today, none of the current discourse on the subject gives me any satisfaction that the underlying issues have been grasped, let alone confidence that the right measures are being taken to change the situation (cited in Neill, p. 12).

Ways Forward (Swan & Raphael, 1995) outlined a major theoretical and practical shift in the planning and implementation of Aboriginal mental health policy, services, programs and therapeutic treatments. The overarching framework of the plan advocated holistic health care designed and delivered according to a population health approach emphasising mental health prevention and promotion. At all levels of intervention the framework sought to promote equality and empowerment for Aboriginal people, as well as cultural values and practices, all essential ingredients in facilitating the mental health and wellbeing of Aboriginal people and communities.

Swan and Raphael urged increased governmental impetus to address the crisis in mental health and socioeconomic conditions in Aboriginal communities. They recommended widespread allocation of funds and resources into Aboriginal specific mental health programs connected to mainstream services, Aboriginal Community Controlled Health Services (ACCHSs also known as AMSs in some States), and training and skill building to increase Aboriginal people in the mental health workforce and enhance the capabilities of non-Aboriginal staff to work more appropriately with Aboriginal people and communities. Swan and Raphael also recommended the development of research to build up an evidence-base of Aboriginal mental health and wellbeing, including evaluation of intervention approaches. The *Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan (1996-2000)* (*Action Plan*: Social Health Working Group, 1996) was developed by the Commonwealth Government's Office of Aboriginal and Torres Strait Islander Health Services to address the recommendations outlined in *Ways Forward* (Swan & Raphael). An evaluation of this *Action Plan* was published in 2001 (see Urbis, Keys & Young, 2001).

Advances in mental health service delivery for and with Aboriginal people have occurred since *Ways Forward* (1995) and the *Action Plan* (1996-2000). These include increased numbers of ACCHSs, trained Aboriginal Mental Health Workers (AMHWs), enhanced cultural competence of non-Aboriginal workers, more culturally appropriate services, programs and therapies and generally improved access to services, although huge variations exist across Australia (Urbis et al., 2001). The release of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental health and Social and Emotional Wellbeing (2004-2009)* (Social Health Reference Group, 2004) provided a more formalised and coordinated framework for national action to address the mental health and wellbeing of Aboriginal people and communities. Despite this, inquiries, research and reports have continued to demonstrate the inadequacies of existing policy, services and programs to significantly improve the mental health and wellbeing of Aboriginal people and communities (Gordon, Hallahan & Henry, 2002; Human Rights and Equal Opportunity Committee [HREOC], 1997; Hunter, 2007).

3.2 A Holistic Framework for Aboriginal Mental Health Intervention

Aboriginal people have persistently been pervaded with non-Aboriginal informed intervention in all aspects of their lives. Mental health intervention for Aboriginal people has been no exception, provided mainly through mainstream services which utilise the Western medical model (NAHSWP, 1989). Formulated in Europe in the seventeenth century, Descartes' notion of the separation between the mind and body with the focus on disease or illness as separate from other dimensions of the person informed the development of Western medicine and psychiatry. The medical model

presumes that mental health problems are biologically determined, caused by factors inherent to the individual; treatment is focused on the individual and medications are used to alleviate disease (Tudor, 1996). Waldegrave (1993) stated that Westernised approaches conflict markedly with the Aboriginal worldview. Brady (2004) noted however, that the spotlight on cultural difference in conceptions of Aboriginal health and wellbeing and the belief that the Western system is purely bio-medical is an oversimplification of Aboriginal and Western constructs of health and wellbeing and outlined the need to understand the similarities and appreciate the differences.

The National Aboriginal and Islander Health Organisation (NAIHO, 1982) first defined health from an Aboriginal perspective. This definition was included in the *National Aboriginal Health Strategy* (NAHSWP, 1989) as follows:

> Health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community (p. x).

Swan and Raphael (1995) related this definition to Aboriginal mental health and explained that Aboriginal people view mental health as a holistic concept which incorporates physical, mental, emotional, spiritual and cultural wellbeing. Aboriginal conceptions of mental health do not include the mind-body dichotomy articulated in Westernised beliefs about mental ill-health (Vicary & Bishop, 2005). Aboriginal notions presume causality lies outside the individual, ill-health may be influenced by external forces such as “bad spirits”, or “supernaturally enforced punishment” (Gray, 1980, p. 178), or related to being “sung” by an aggrieved party, married “wrong-

way" or acting inappropriately during Law business (Vicary & Bishop, 2005, p. 11). Mental health is viewed in the context of overall wellness or wellbeing as opposed to Western conceptions of ill-health which focus on disease or disorder (Hunter & Garvey, 1998).

Although there are diversities, Aboriginal people identify as part of the group rather than individualistically. The person is located within the broader context of family, community and society where individual wellbeing is dependent on the overall wellbeing of the community (Swan & Raphael). McLennan and Khavarpour (2004) explain that Aboriginal wellbeing is strongly influenced by connection to family, community, culture, spirituality and land which shapes identity. Thus, family, community and clan play a large part in the conceptualisation of wellness and the healing process (Clarke & Fewquandie, 1999). Therefore, mental health intervention needs to be located within the broader notion of Aboriginal mental health and include an understanding of the physical, social, emotional, spiritual and cultural wellbeing of the individual in relation to their environment, family, community and clan (Swan & Fagan, 1991; Swan & Raphael).

Research and intervention informed by non-Aboriginal conceptions of mental health have resulted in a narrow view of the mental health and wellbeing of Aboriginal people. This has limited efforts to accurately define the extent and impact of mental health and social and emotional problems in Aboriginal populations and resulted in inequitable and culturally inappropriate intervention at individual and community levels (NAHSWP, 1989; Raphael & Swan, 1997; Swan & Raphael, 1995).

Swan and Fagan (1991) reported that individually based treatments in isolation are inappropriate for Aboriginal people. Reliance on the medical model has resulted in overuse of medication as the "choice" of treatment for mental suffering in Aboriginal clientele. For example, non-Aboriginal practitioners used medication to treat child behaviour problems and maternal depression in victims of the Stolen Generations rather than incorporating an understanding of the impact of the wider socio-historical conditions on Aboriginal mental health (Eastwell, 1985). Aboriginal people involved in *The Consultancy* believed that psychotropic medications were overused, failed to help with their problems, and often created additional difficulties (Swan & Raphael, 1995). Eckermann et al. (2006) pointed out that the medical model approach aims to treat the problem not the person and thus the person is divided into discrete parts (mental, physical, social, spiritual) resulting in compartmentalised intervention. This is also true in other areas of intervention into Aboriginal people's lives.

Pearson (2000) argued that a fundamental failure of government has been their inability to address Aboriginal issues in a holistic way due to a Western dominated worldview. At Federal, State and local levels separate departments and agencies have been designed to address health, mental health, education, welfare, justice issues (to name some) in the population generally. These services have operated independently, encouraging the term "silo approach". However, the problems in Aboriginal communities are interrelated and do not correspond to the way these services are organised (Gordon et al., 2002). For example, it has been difficult to address health in isolation to social issues (Pearson). Aboriginal alcohol policy which guides service and program delivery has been developed in isolation from other areas influencing Aboriginal wellbeing such as health and mental health, failing to understand and

address the interconnection of problems (Brady, 2004). Services within departments such as health are also segregated from each other, as Gray (1980) outlined decades ago the problem with having preventative and treatment services in different agencies, is that Aboriginal people see their problems as holistic and "do not neatly divide health care into preventative and therapeutic categories" (p. 172). Gray explained this caused confusion and conflict amongst services and Aboriginal people who perceived these services as culturally inappropriate and were reluctant to access them. Compartmentalisation of service delivery is increasingly recognised as a problem for both Aboriginal and non-Aboriginal people.

The development of Aboriginal organisations has also occurred within this mainstream compartmentalised framework. Pearson (2000) explained that in remote communities there are separate Aboriginal controlled services and programs dealing with health, community development, land and governance. The isolation of departments and agencies has resulted in a lack of coordination, collaboration and agreement of roles and responsibilities for the delivery of services and programs in Aboriginal communities. This model of service delivery has also resulted in competition for scarce resources, duplication of services, and under-utilisation of services by Aboriginal people. These shortcomings in service delivery have contributed to the increasing mental ill-health and wellbeing problems in Aboriginal communities (Gordon et al., 2002; HREOC, 1997; Pearson; Swan & Raphael, 1995). Governments have attempted to overcome these problems through establishing inter-departmental committees and inter-agency agreements but have not yet overcome the problem of addressing Aboriginal issues holistically (Pearson). Gordon et al. recommended a redesign of agencies and services and suggested a "one-stop-shop"

to incorporate the interrelatedness of problems and their associated risk factors, where Aboriginal families can be provided with integrated assistance to meet their needs.

3.3 Core Principles to Incorporate into Aboriginal Mental Health Intervention

In *Ways Forward*, Swan and Raphael (1995) recommended mental health promotion intervention with Aboriginal people and communities needs to incorporate the principles of social justice, empowerment, cultural values and practices in order to promote mental health and wellbeing.

3.3.1 Human Rights and Equitable Service Provision

One of the main risk factors for poor mental health and wellbeing is inadequate social and economic conditions. This includes reduced access to services and programs or ineffective services and programs resulting in under-utilisation (Zubrick et al., 2005). For Aboriginal groups in particular discrimination poses a significant risk of mental ill-health where opportunities (e.g., education, employment) are reduced. Aboriginal people living in rural and remote areas are further disadvantaged where basic resources and services are scarce (Commonwealth Department of Health and Aged Care [CDHAC], 2000). Following the 1967 Referendum the Aboriginal community increased demands for social justice and later for equal rights to health and mental health care (Hunter & Garvey, 1998). Prior to that, as Cawte (1996) reflected on the early days (c1949) of mental health intervention with Aboriginal people:

> We used to get a stream of very upset Aboriginal people from remote areas of South Australia and the Northern Territory which at that time had no services for Aboriginal people. In fact the system they had for handling disturbed patients was to call the police in and have them removed. The police would then bring them down to the Reception House (mental health facility) (p. 24).

Atkinson (1990b) reported that Aboriginal women suffering from family violence and sexual abuse who reported to police were often met with inaction and some reportedly suffered further abuse by local police. The extent of Aboriginal mental ill-health and distress was unacknowledged, resultant symptoms and behaviour were often labelled as deviant and treatment occurred ad hoc if at all. Major inquiries into Aboriginal health, mental health and wellbeing have demonstrated that the greatest area of need has been met with the least attention, funding and resources (Gordon et al., 2002; NAHSWP, 1989; Swan & Raphael, 1995).

Swan and Raphael (1995) argued that the human rights of Aboriginal people must be recognised and respected and failure to do so will have continued detrimental impact on Aboriginal mental health and wellbeing. Calma (2004) acknowledged that human rights in relation to Aboriginal people have been poorly defined. He defined human rights as,

> objective standards that are intended to transcend particular legal systems, ideology or political persuasion. Human rights are intended to reflect the core of humanity – setting out standards of treatment that individuals and groups

should receive for no other reason other than that they are members of the human family (p. 19).

Ways Forward (Swan & Raphael, 1995) stressed the need to address Aboriginal human rights in relation to mental health care through the provision of quality and appropriate services and programs equal to that of other Australians. Additionally, Swan and Fagan (1991) emphasised that until the underlying causes of mental ill-health in Aboriginal communities, the social, economic, cultural and political disadvantage, are addressed, disproportionately high rates of mental health and social and emotional problems will persist and the impact of mental health services and programs will be limited. Hunter and Garvey (1998) perceived this task as both "daunting and pressing" (p. 4). Swan and Fagan called for increased education and employment opportunities, improvements in housing and physical environments in Aboriginal communities. Services and programs have increased over the last decade however problems have worsened in some Aboriginal communities with endemic rates of substance abuse, suicide, child abuse and violence (Gordon et al., 2002; Pearson, 2000). It is widely agreed that more resources are needed to tackle these problems and redress the disadvantage. However, resilience for high risk groups extends beyond social and economic conditions to include provision of adequate power and control over one's life circumstances (Eckermann et al., 2006). This is still lacking in the lives of many Aboriginal people.

3.3.2 Empowerment

The concept of empowerment has been cited in every major report into improving the lives of Aboriginal people and their communities. Empowerment is critical

among the Aboriginal community where risk for poor mental health and wellbeing is closely related to factors that have resulted from the removal or suppression of autonomy and control from Aboriginal people since colonisation (Kirmayer, Simpson & Cargo, 2003; Mitchell, 2000). Aboriginal people suffer a variety of risk factors (e.g., welfare dependence, high levels of stressful life events, social exclusion, childhood adversity) that combine to contribute to a perceived lack of personal control over their own lives (Hunter, 1993; Memmott et al., 2001; Zubrick et al., 2005). Altman (1995) pointed out that empowerment for individuals includes their beliefs about control, competence, motivation to act on these beliefs, direct involvement in activities where control is exerted and having decision making/problem solving skills to negotiate successfully in social and political environments. Communities are empowered when there is opportunity and support for individuals and groups to participate equally in the life of their community, shape community agenda, participate in decision making and have access to resources within and outside the community. Access to resources includes exchange of skills and information with governments and other services to seek resources to achieve the goals set by the community (Altman; CDHAC, 2000; Rappaport, 1994).

Trudgen (2000) asserted that for Aboriginal people "control is the essence of good health" (p. 219). Community Psychologists Zimmerman and Rappaport (1988) stated that the empowerment process includes the actions and policies designed to build the degree of control disadvantaged people have over their lives. This involves critical examination of the oppressive socio-political structures at local and societal levels (e.g., government policy, programs, services) that prevent individuals from controlling their lives (Prilleltensky & Nelson, 1997) and transforming oppressive

structures and redistributing resources to give control back to people to determine their own futures (Sonn & Bishop, 2000). Therefore, Aboriginal empowerment is dependent on the motivation and capability of Aboriginal people to take control over their own lives, and the assistance and support of mainstream society, particularly governments and their departments, to facilitate this process (Pearson, 2000). Importantly, Eckermann et al. (2006) explain "empowerment is not a thing it is a process therefore no individual can empower another, opportunities must be created for people to empower themselves" (p. 178).

3.3.2.1 Self-determination

The self-determination era gave Aboriginal people the means for empowerment where no prior social or political basis had existed. Individuals could become citizens, vote, receive equal pay and drink alcohol; families received financial benefits, were no longer subjected to legalised removal; and groups were awarded funds to establish community controlled services and ascertain rights to traditional lands. From its inception into Aboriginal policy, self-determination has been ill-defined (Neill, 2002). Self-determination is a fundamental right of all people, however what this "right" constitutes is the subject of ongoing debate (HREOC, 1997). Community Psychology views self-determination as synonymous with participation (Prilleltensky & Nelson, 1997). The draft *Declaration on the Rights of Indigenous Peoples* stated that Aboriginal people have the right to control their political, economic, social and cultural development as well as their legal systems, have the resources and capacity to control the future of their own communities within the legal structure common to all Australians, while retaining their rights to participate fully, if they choose, in the political, economic, social and cultural life of

the State (HREOC, p. 563). Self-determination, in the context of mental health service delivery, involves providing Aboriginal people with the power, training and resources to determine their own mental health interventions within their own terms of reference (Swan & Raphael, 1995).

Eckermann et al. (2006) explained that through self-determination and self-management Aboriginal people should have been able to fully decide the course of their lives and to live according to those choices. However, Aboriginal people have been subjugated under this system with imposed structures and systems, and little support. In practice self-determination has meant "we'll (the government) help you to do what we want you to do" (p. 28). Self-determination has oscillated between governmental denial of responsibility and continued control over Aboriginal affairs (Bolger, 1991). Pillars of self-determination (e.g., Aboriginal and Torres Strait Islander Commission [ATSIC], Native Title) have come and gone without substantial improvement in the wellbeing of Aboriginal communities (Eckermann et al.; Neill, 2002).

3.3.2.2 Control

The extent of meaningful control for Aboriginal people to determine their own lives and the efficacy of "Aboriginal control" in terms of promoting Aboriginal wellbeing has varied. Brady (2004) argued that the assertion of Aboriginal control and cultural differences in Aboriginal health and wellbeing contributed to government indifference or a "hands off" approach to Aboriginal service provision instigated in the self-determination and self-management eras. For example, in relation to violence in Aboriginal communities Bolger (1991) outlined that police believed

community councils alone needed to control violence and alcoholism. During this period, governments also developed a culture of "oversensitivity" whereby policy formation and decision making with regard to Aboriginal health and wellbeing was avoided for fear of making mistakes or offering advice. As a result there has been decades of inattention and inaction in relation to the growing problems in Aboriginal communities.

In relation to remote Aboriginal communities, Brady (2004) asserted that self-determination implied Aboriginal communities needed to be responsible for all decision making and management, however the *National Aboriginal Health Strategy* (NAHS) report showed that despite the majority support for community control, some communities believed they did not have the resources and expertise to subsume this level of self-management and were consequently overwhelmed with administration (NAHSWP, 1989). Trudgen (2000) reiterated that communities became overburdened administering services and programs which in the general population were run by government departments. The transfer of expertise and resources for effective self-management and control failed to occur (Tann, 2002). The push for control and self-determination has been detrimental in some instances where increased separatism amongst Aboriginal and mainstream services has reduced access to expertise, resources and support from the mainstream sector (Brady, 2004).

There have been many advantages to the expansion of Aboriginal controlled organisations. However, Pearson (2000) argued that distribution of funds for these services is still managed by the government and these services are at the whim of

changing policies which disband one Aboriginal organisation only to set up another (as in the case of ATSIC). The mainstream government approach to service delivery in Aboriginal communities has been structured to gather expertise, resources, decision making (power) at the top-end of bureaucracy (State, Federal) which legislates, approves and administers funds. This formula removes control from Aboriginal communities undermining the empowerment process. The system of community governance (e.g., councils, leaders) also keeps power (e.g., decision making, resources, responsibility) away from community people. Neill (2002) concluded that Aboriginal people are yet to take meaningful control over their lives.

Pearson (2000) emphasised that meaningful control for Aboriginal people won't happen while administrative, decision making and funding processes are determined by government driven policy, departments and community councils. Essentially, the very structures that support oppression must change. A shift from a top-down approach to planning and implementing services and programs involves a change in the relationship between Aboriginal communities and governments at Federal, State and local levels to enable community control over policy, program development and funding administration (Kirmayer, Simpson & Cargo, 2003). This has been a major stumbling block for governments. Eckermann et al. (2006) argued that non-Aboriginal people need to trust that Aboriginal people can make their own decisions and hand over power and control to the community.

3.3.2.3 Participation

International research with Canadian Aboriginal communities suggests that the low success rate of programs for Aboriginal people can be attributed to a lack of

Aboriginal participation in program development and implementation (Kirmayer et al., 2003). In an Australian context, Neill (2002) reported that one of the problems with self-determination is that Aboriginal people failed to have meaningful input at the policy level. Aboriginal participation is often limited to consultation and discussion after policy, service, or program decisions have been made by governments, rather than involvement in initial prioritising and decision making (Eckermann et al., 2006). *The Gordon Inquiry* identified that Aboriginal communities need a greater role in formulating services and programs instead of having to choose from a range of predetermined options (Gordon et al., 2002).

From his work with socially disadvantaged communities in the United States, Syme (1997) concluded that motivation for social and behavioural change came from individuals and communities rather than outside "experts". Creating opportunities for participation, such as asking communities what their problems were and what the possible solutions entailed, resulted in increased confidence and resourcefulness in solving individual and community problems and overall control over people's lives. For young Aboriginal people in particular, giving them an active role in designing and implementing initiatives to meet their needs can promote positive identity and self-esteem (Kirmayer et al., 2003). Trudgen (2000) explained that when communities initiate a response that accords with their cultural ways and physically implement what they have decided upon, problems can be solved.

3.3.2.4 Responsibility

Pearson (2000) views self-determination for Aboriginal people as the right to take responsibility. He believes that the breakdown in Aboriginal society is closely related

to the breakdown in responsibility for one's own health and wellbeing; for family, particularly children and for contribution to one's community. According to Pearson, the mentality and methods of governments to pay welfare, provide services and implement programs to address the problems in Aboriginal communities has encouraged passivity and stripped Aboriginal people of their sense of responsibility and control in enacting solutions to their own problems, hence undermining the empowerment process. Crawford (1989) explained that without meaningful involvement and control by Aboriginal people in the design and implementation of services and programs, interventions potentially weaken the autonomy of Aboriginal communities to deal with their own problems.

Pearson (2000) posed the question "why is it so hard to get change happening on the ground" in Aboriginal communities when communities such as those in Cape York have the workforce and councils have the resources and equipment (p. 44). Over time processes have resulted in Aboriginal disempowerment through removal of responsibility, resulting in apathy, dependence and inaction (Trudgen, 2000). In terms of health, the medical model places responsibility for treatment in the hands of experts (e.g., doctors) or a "program", removing it from the individual, family and community. People are not responsible for creating their problems or fixing them (Lewis, Lewis, Daniels & D'Andrea, 1998; Smith, 1999; Tudor, 1996). Pearson explained that continued provision of welfare, services and programs by non-Aboriginal or Aboriginal people outside of communities has resulted in Aboriginal people believing the solutions to their problems lie outside themselves, in the hands of "White" people, governments or other Aboriginal people. Trudgen (2000) also acknowledged that many interventions based in Aboriginal communities which are

run by non-Aboriginal people, although well intentioned, remove Aboriginal people of their roles and responsibilities. For example, school feeding programs or sending young people on holidays have raised expectations of what can legitimately be done in normal family life and removed responsibility for care of youngsters from the family and community.

Pearson (2000) further outlined reasons for community inaction. These include: the communal nature of communities means that people leave it up to someone else to initiate ideas and do the work; people get frustrated by constraints on program parameters (e.g., Community Development Employment Projects [CDEP], health promotion activities) that are perceived to be out of their control (under government/outsider control) and give up thinking things can change; and power resides in community leaders who are so swamped with administrative tasks that they have no time to facilitate change. Additional reasons for lack of community action includes: funding is controlled by government departments or funding bodies and people wait for funding to start initiatives they could do without waiting for funding, and stop when the funding runs out; people wait for outside experts to come and fix problems because that is what they are used to; they wait for further education and training from outsiders because that is what they have been told they need before they can initiate a response.

Building responsibility needs to occur at all levels. For individuals this requires self-care (not abusing alcohol) and self-improvement (education, skills, knowledge and training). Family responsibility requires the nurturance, protection, education of children and care for the elderly. Community responsibility requires working for the

common good. The mainstream sector must make attitudinal changes and structural changes in governments and service delivery to allow Aboriginal people their right to take responsibility over their own lives in order to improve their health and wellbeing (Pearson, 2000).

3.3.2.5 Leadership and Governance

Pearson (2000) explained that there are two systems of governance operating in Aboriginal communities. The formal system of government, consists of community councils established by the State and Aboriginal and non-Aboriginal organisations incorporated under State and Federal laws. The informal system operates under the laws, customs and values of the people. These two systems are incongruent. Pearson described four "models of leadership" which have dominated governance in Aboriginal communities: The "White dictator model" – non-Aboriginal people working in communities much like their historical counterparts did, controlling, encouraging passivity with little accountability; "Black dictator model" – similar to the White version, also succumbed to "power tripping" by running their own systems with people under their control. The "White saviour/servant model" - parallels the good hearted, well intentioned missionaries. These people come and try to save or serve Aboriginal people, an approach that is subtlety destructive and pacifying but predominant in communities. The "Black saviour/servant model" - Aboriginal people who have been educated in the wider context feel sorrow, pity and see other Aboriginal people as helpless. They become leaders who set about trying to save their communities, characteristic of senior Aboriginal leadership. Pearson stressed that all these modes of operation create "leaders and followers" (p. 57). For this and other reasons, governing systems in Aboriginal communities are fragmented, marred

by nepotism and family fighting. Power and resources are controlled by family factions which is oppressive to other families and halts community progress (Gordon et al., 2002; Pearson). Eckermann et al. (2006) revealed that internal community processes (e.g., infighting, factionalism, family nepotism) are barriers to self-determination, as these problems reinforce non-Aboriginal perspectives that communities waste precious resources, can't solve their own issues, need to be controlled and made more accountable.

The Gordon Inquiry strongly advocated for the development of governance, management and leadership capacity to combat social and emotional issues in Aboriginal communities (Gordon et al., 2002). Pearson (2000) argued that Aboriginal governance and leadership requires promotion of traditional Aboriginal values and processes such as coordination, cooperation, unity, respect of other's rights, sharing power, taking responsibility and encouraging others. Decision making needs to move away from the "White-fella" way of majority votes rule to an Aboriginal consensus model which involves the whole community. He asserted that the challenge is for people to put their conflicts aside to confront complex issues and for community leaders to rise above their family obligations and demands to promote community needs. Governance requires systems akin to Aboriginal Law where disputes can be settled while appreciating conflicts of interest and maintaining values. Leadership must be based on responsibility at all levels from family, clan, community and society, where power (rights, responsibilities and resources) is designated to individuals not institutions (e.g., councils, governments). This will involve a holistic framework that involves representation, coordination and cooperation at local, regional and political levels.

3.3.2.6 Skills and Resources

The skills and resources of Aboriginal people and communities have been eroded through oppressive and paternalistic approaches. For example, traditional values, knowledge, systems and structures have been interrupted. The "Stolen Generations" and institutionalisation of children has been linked to decreased parenting resources, skills, parenting confidence and competence in Aboriginal people (HREOC, 1997; Zubrick et al., 2005). Lack of employment and educational attainment has contributed to skill reduction in young people. Passive receipt of welfare, services and programs has further reduced access to skills, knowledge and expertise (Pearson, 2000). Over time, this has culminated in decreased personal efficacy, confidence, and diminished ability to have control over one's destiny, resulting in further oppression and dependence (Trudgen, 2000). People with diminished resources exposed to continued adversity become overwhelmed by the totality of their problems and find it difficult to cope. Existing resources and capacities are utilised to deal with day to day problems or crises which makes community action difficult and social change virtually impossible (Pearson). Tann (2002) stated that the lack of progress in Aboriginal communities is linked to the diminished capacity of individuals and communities to cope with the situation. Therefore, building capacity is critical to facilitate change.

Social capital or skills, knowledge and resources are pivotal for self-determination and empowerment (CDHAC, 2000). This involves acquisition of social capital necessary to negotiate and navigate in all areas of living - interpersonal, familial, community and in socio-political spheres. For individuals this means enhancing personal competence through development of social and cognitive coping skills (e.g.,

parenting skills, relationship skills, anger management) and enhancing problem solving skills to devise solutions and mobilise resources to implement solutions (CDHAC; Maton, 2000). From a developmental perspective, enhancing psychosocial competence increases a child's ability to master developmental challenges, deal more effectively with stress and negative life events. This can increase self-efficacy and a sense of control over their fate which can provide a buffer against mental health and wellbeing problems (Cowen, 1991; Durlak, 2000; Spence, 1996). Lewis, Lewis, Daniels and D'Andrea (1998) explained that in order to foster a sense of responsibility, opportunities need to be created for people to experience success and thus recognise their own power. For example, learning social skills and applying these skills with success can result in greater self-efficacy and increase the likelihood of managing future difficulties. Clarke, Harnett, Atkinson and Shochet (1999) advocated that interventions are required to promote positive parenting skills and practices in Aboriginal families to increase parenting confidence and competence, and provide a protective childhood environment. For communities, training in management, governance and leadership will strengthen self-management and enhance capacity to facilitate change (Gordon et al., 2002; Tann, 2002).

To enact socio-political change and increase empowerment (e.g., decision making, resource acquisition), Aboriginal people require increased awareness of how political structures and processes, both locally and at State and Federal levels, impact on their lives as well as the knowledge and skills to deal with the complexities of government policy, programs, services, funding and funding providers. Where skills and knowledge are required, the community must be in control to determine what is needed and how this capital is transferred to the people (CDHAC, 2000).

Pearson (2000) acknowledged that knowledge and skills facilitation is important but stated that there is also a need to recognise that changes in Aboriginal communities can be made without waiting for more skills, resources or funding because vast resources and expertise exist in Aboriginal people and communities. He maintains that existing capacity needs to be encouraged and developed instead of waiting for "qualified" (usually outside) people to make changes. Pearson explained that "most of the things we need to do to develop our communities are not rocket science and our people are quite capable" (p. 47).

The detriments of reliance on welfare, including the programs provided by governments to address social and emotional problems in Aboriginal communities has been highlighted by Pearson (2000) and others (e.g., Trudgen, 2000). At this point Aboriginal communities wouldn't survive without government provisioning because there is no real economic alternative, especially in remote areas. Therefore, how resources are distributed and managed needs to change and Aboriginal communities must be able to build an economic base through meaningful sustained paid employment rather than reliance on welfare and paid outsiders (Pearson; Calma, 2004).

3.3.3 Culture and Connectedness

Through culture, connection and belonging to land, family and clan/tribe Aboriginal society traditionally had ways of promoting and sustaining good physical, social, mental, emotional and spiritual wellbeing (Hunter & Garvey, 1998). Western colonisation and domination fragmented or destroyed much of this fabric, having a devastating impact on Aboriginal society, identity formation (individual and

collective), relationships and belonging to person and place, culminating in extreme trauma and loss over several generations (Atkinson, 2002). A sense of belonging to family and community, cohesiveness of these connections and identification with cultural and spiritual values and practices are intrinsically linked to identity and overall wellbeing (McLennan & Khavarpour, 2004). For Aboriginal people, inadequate social supports (due to substance abuse, violence, family breakdown, inappropriate mainstream responses) has lead to further disconnection from self and others. Prolonged denial of culture and separation from country has further disrupted identity, family and community cohesion and overall mental health and wellbeing (Clarke, Harnett, Atkinson et al., 1999; Vicary & Bishop, 2005). Building social support networks within a community has been shown to significantly improve the mental health and wellbeing of individuals and communities and reduce the detrimental impact of socioeconomic disadvantage and trauma (Health Education Authority cited in CDHAC, 2000). CDHAC explained that creating supportive social, economic, cultural and physical environments contributes markedly to increased mental health and wellbeing by facilitating a sense of belonging, ability to actively participate in social life and strong social support networks.

Aboriginal people have shown enormous resilience despite their history, maintaining cultural practices, extended family relationships and clan connections and these strengths need to be encouraged (Swan & Raphael, 1995). The consensus in the literature is that Aboriginal wellbeing both individually and collectively depends on the "respect, renewal and adaptation" of processes removed, denied or ruined by past and current practices (Hunter & Garvey, 1998). HREOC (1997) declared that past removal and institutionalisation of Aboriginal children grossly interfered with the

learning and enjoyment of culture, spirituality, language and Law. Interventions designed to strengthen the wellbeing of communities need to incorporate cultural activities which promote cultural values, enhance individual and community identity and connection to family, community and country (Clarke, Harnett, Atkinson et al., 1999; HREOC; Swan & Raphael; Trudgen, 2000). Pearson (2000) strongly argues that "central to the recovery and empowerment of Aboriginal society will be the restoration of Aboriginal values and Aboriginal relationships, which have their roots in our traditional society" (p. 20).

International research demonstrates that efforts to restore cultural traditions and practices have been seen as acts of healing by Aboriginal people (e.g., knowing language, hunting, returning to country to carry out cultural practices and facilitating relationships with family and community) and interventions must consider these practices for Aboriginal people to assert cultural identity (Kirmayer et al., 2003). Encouragement of spiritual and cultural practices including ceremonies, art, storytelling, dance, community and family gatherings was essential to enhancing identity, family and community connectedness and overall wellbeing in a NSW Aboriginal community (McLennan & Khavarpour, 2004). Vicary and Bishop (2005) reported that Aboriginal people believe it essential to return home to their traditional country to renew spiritual connectedness and enhance identity. Therefore, incorporation of cultural activities into interventions can strengthen the wellbeing of individuals, families and communities, enhance individual and collective identity and promote healing. Cultural activities need to be prioritised, designed and run by the community to embrace the diversity of Aboriginal values and cultural practices.

3.4 A Population Health Approach: Mental Health Promotion and Prevention

In *Ways Forward*, Swan and Raphael (1995) proposed a population health approach incorporating prevention, promotion and early intervention. The authors prioritised intervention with young people, the need for programs to focus on identifying and managing child abuse, substance abuse, violence, suicide, enhancing identity, self-esteem, social skills, parenting skills, encouraging cultural practices and facilitating healing from past and current trauma and loss.

Major shifts in the conceptualisation of Aboriginal mental health have coincided with developments in mainstream mental health which has allowed for a more holistic, contextually-driven approach to mental health intervention. Tudor (1996) explained it took over three centuries for Western medicine to redefine health and health intervention when it acknowledged that environments, lifestyles and behaviours in addition to biological factors contributed to poor health outcomes. The public health movement emerged (later renamed population health), advocating a shift from the medical model approach to whole population prevention and health promotion. The first International Conference on Heath Promotion (ICHP) in Ottawa, Canada in 1986 proclaimed a charter for health promotion now known as the *Ottawa Charter* (World Health Organisation, 1986). Health promotion was defined as:

> a process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to

> satisfy needs, and to change or cope with the environment (ICHP, 1987, p.iii, cited in Tudor, 1996, p. 36).

The *Ottawa Charter* emphasised "building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting services toward promotion, prevention and early intervention activity" (Walker & Rowling, 2002, p. 4). This approach has since been adopted by the mental health field and endorsed by governments due to mounting evidence that an approach which includes promotion, prevention and early intervention alongside treatment and relapse prevention can have widespread benefits in improving the mental health and wellbeing of all Australians and reducing the prevalence and burden of mental health problems and disorders (CDHAC, 2000).

Mental health promotion aims to protect, support and sustain the emotional and social wellbeing of the community and individual by promoting factors which enhance mental health and resilience rather than preventing or treating mental illness per se. This includes improving environments that affect mental health and enhancing coping capacity of individuals and communities (CDHAC, 2000). For young people, this can incorporate building family and community support and skills to enhance self-esteem and self-efficacy (Werner, 1993). Prevention includes interventions that are initiated before the onset of mental health disorders or prevent the development of disorders by focusing on reducing risk and enhancing protective factors. Preventative intervention can be *universal* (targeted at whole populations not identified as being at risk), *selective* (targeted to individuals or sub-groups of the population where risk is proportionately higher than the general population),

indicated (targeted at individuals or sub-groups whose risk is identified as minimal) (Mrazek & Haggerty, 1994). There is substantial evidence that competencies in children and youth, families and school environments in the general population can be enhanced and mental health and wellbeing problems (e.g., aggression, internalising problems, school disruption) reduced through mental health promotion and prevention interventions (Durlak, 2000; Durlak & Wells, 1997).

Early intervention typically targets people displaying the early signs and symptoms of a mental health problem or disorder. Spence (1996) explained that mental health problems continue to develop into more debilitating disorders later in life and evidence suggests that if help is given to young people early in their development, mental health problems can be prevented or their impact on family and community greatly reduced. For example, problems like depression, anxiety and suicide can be prevented through early intervention (Durlak & Wells, 1997; Roberts, 1999). Applying the goals of mental health promotion to Aboriginal contexts fits well with Aboriginal notions of health which emphasise wellness and strengths (Swan & Raphael, 1995). However, methods are compromised in Aboriginal communities where identification of specific sub-groups based on risk is difficult in that whole communities are at risk (Hunter, 1998a). Brown, Hunter and Whiteside (2002) assert that in relation to promoting mental health and wellbeing in Aboriginal young people, a "whole of community" response is required.

3.4.1 Community-based Mental Health Promotion

Strongly influenced by developmental psychology, particularly resilience research, the field of mental health promotion has increasingly recognised the varying

pathways to mental health and wellbeing, such as the interrelatedness of risk and protective factors operating at different developmental stages across contexts (Cowen, 1991). Subsequently interventions have extended beyond improving individual competence to addressing other levels of influence (e.g., family, school, community) in order to initiate change in the individual, family and social systems (Durlak, 2000; Riley & Masten, 2005). Unless fundamental changes occur across multiple levels of the social environment, interventions to promote resilience in young people will fall short. Intervening at these levels can reduce environmental risk and increase protective processes in family, school, community and societal systems (Maton, 2005). This shift in understanding has necessitated a more cross-disciplinary approach to intervention design and implementation (Rowling, 2002).

Prilleltensky and Nelson (1997) explained how early on the field of Community Psychology was strongly influenced by the public health movement and in turn transported a more ecological version of prevention and promotion into mental health, expanding the approach from individual to community-based intervention. Importantly, they pointed out the shortcomings of the original mental health promotion approach to promote mental health in populations disadvantaged by their social, economic and political circumstances where processes for empowerment are crucial to wellbeing (Cowen, 1991). Intervening at the micro level (e.g., individual, family) or the meso/middle level (e.g., workplaces, schools) is limited when efforts are undermined by factors operating at the macro level (e.g., socio-political systems which promote unjust social conditions). Therefore intervention is required at all levels (e.g., individual, family, community, socio-political) (Prilleltensky & Nelson).

The focus on ecological variants has challenged mental health promotion to incorporate the wider context, including cultural factors. Trickett and Birman (2000) outlined that creating interventions for culturally diverse groups requires exploration of the specific local and wider socio-cultural context, and questioning whether the intervention fits with the particular characteristics and culture of the community as well as the policies and norms of community institutions (e.g., schools). The authors argued that psychologists must work differently to factor in varying environmental conditions across different contexts and "designing manualised, packaged interventions that can work across contexts, albeit with modifications, is not the preferred strategy" for culturally diverse groups (p. 378). Mental health promotion has mainly been concerned with assessing the "cultural appropriateness" of predetermined programs, instead, Trickett and Birman argue that it is more important to develop processes that allow interventions to *emerge* from collaboration and involvement with the local community so definitions of wellbeing and interventions can have cultural and ecological validity. From an empowerment perspective, Rappaport (1994) emphasised that deviating from the public health preferred model of packaged programs and allowing interventions to emerge in context through collaboration is essential to empowerment. Blending promotion and prevention with community-based strategies is a cost effective approach by which interventions can have an impact at several levels (Durlak, 2000).

Maton (2005) argued that interventions aimed at transforming the social environment to promote resilience in children should include four interrelated processes: (1) *capacity building* which emphasises participation in analysing problems and devising solutions, is strengths-based, enables mobilisation of resources from within the

community, increases problem-solving capability and leadership; (2) *group empowerment* which aims to increase access to opportunities, skills (e.g., personal, economic, political), resources and power for oppressed and marginalised groups through control, equitable distribution of resources and skill building; (3) *relational community building* which involves bringing people together to encourage connectedness, inclusiveness, support and shared meaning; and (4) *culture-challenge* which aims to address the belief systems, social norms and values, cultural practices embedded in social systems that undermine or promote resilience for youth, including modifying mainstream values that encourage individual materialism over balanced resource distribution. The goals and methods of a community-based mental health promotion approach, including those exemplified in Maton's model parallel the goals and strategies of intervention identified for Aboriginal communities. Moreover, community-based mental health promotion intervention allows interventions to occur within a holistic framework; be integrated into community infrastructure; focus on multiple levels (individual, family, community); address multi-components (interrelated risk and protective pathways); provide opportunities for control and participation; allow goals and methods of intervention to emerge according to local values and needs and be influenced by ecological and cultural factors. An array of intervention activities including community development and policy initiatives are required to bring about social change to build resilience in young people most at risk (Maton, 2000; Maton, 2005).

3.4.2 Community Development

For Aboriginal people, community-based approaches such as community development have long been advocated to promote mental heath and wellbeing

(Hunter, Tsey, Baird & Baird, 2002; Swan & Raphael, 1995). In WA, the Department of Indigenous Affairs has worked with the Aboriginal Suicide Prevention Steering Committee affiliated with the WA Telethon Institute for Child Health Research (TICHR) to find appropriate methods to address social and emotional problems in Aboriginal young people, families and communities. They recommended universal prevention and early intervention initiatives delivered within a community development approach (Tann, 2002).

Swan and Raphael (1995) argued that community development must be "developed and implemented by Aboriginal people, under the control of Aboriginal people who will mobilise other resources (non-Aboriginal) as they determine the need" (p. 20). Community development is suitable for Aboriginal communities where programs that address multi-components (e.g., empowerment, culture, healing) operating concurrently in several domains (e.g., individual, family, agencies, community, governments) are most likely to promote resilience and wellbeing (Maton, 2000; Swan & Raphael). Lette, Wright and Collard (2000) reported that community-based programs are particularly beneficial to Aboriginal youth who often only come into contact with services when in crisis and prefer to access services and programs in their local community. Community-based approaches accord well with Aboriginal concepts of holistic health and healing which espouse individual and family wellbeing as dependent on the overall wellbeing of the community, and couch problems in terms of their relatedness to other community issues (Cheers et al., 2006; Crawford, 1989). Altman (1995, p. 8) argued that "community development and empowerment go hand-in-hand", both emphasise locally defined problems, capacity building, participation and control. Capacity building is an alternative to the outside-

initiated, top-down, expert-driven approach to solving problems (Maton, 2005). The goals and processes embedded in community development provide the means for Aboriginal empowerment through self-determination and wider socio-political change (Garvey, Dudgeon & Kearins, 2000).

Pearson (2000) advocated that in relation to Aboriginal people, community development requires processes that promote personal initiative and responsibility, such as allowing people to find solutions to their own problems through flexibility and freedom for people to think of solutions outside a "passive welfare mentality". In addition, it requires processes which do not get overcome by bureaucracy (e.g., prioritise outcomes then accountability), look toward existing community capacity instead of outside experts, and start acting instead of waiting for funding. Pearson's approach acknowledges that Aboriginal people are not expected to "go it alone". Partnerships are required with governments and community councils in which devolution and sharing of power and responsibility is needed at a local level.

Pearson (2000) identified important questions to ask of any program aimed at addressing the problems in Aboriginal communities, (1) is the program seeking to take responsibility for an issue that was previously the responsibility of Aboriginal families and communities? (2) How did Aboriginal people deal with this issue prior to us (outsiders) thinking they needed a program? (3) Do families and communities actually need resources rather than a program with outside bureaucrats/service deliverers attached? If so, how can families and communities secure these resources other than through the usual government program distribution method? It is also important to appreciate the diversity of Aboriginal people and communities in

planning interventions. Pearson emphasised the need to understand that Aboriginal communities are not homogenous groupings, that individuals and families interact with a great deal of independence, and conflicting views, interests, affiliations must be taken into account in any intervention in an Aboriginal community. Eckermann et al. (2006) suggested that despite the difficulties, communities and outsiders must make a start, identify problems and prioritise their importance, audit community assets and resources such as physical infrastructure, funds, people with specific knowledge, skills and talents. The asset analysis should increase the community's awareness of its strengths. Essentially, Eckermann et al. argued that solutions to problems in Aboriginal contexts need to be generated from within the community and then from this government priorities and policies can be formulated.

Ways Forward (Swan & Raphael, 1995) stipulated a program development and implementation strategy utilising a community development model. For example, communities require a "youth coordinator" to design and implement mental health and wellbeing programs, link in with related Aboriginal and mainstream services and programs to seek desired resources and support, and work collaboratively with the local community (e.g., Elders, families). They envisaged programs would be developed and managed locally but overseen nationally. A consultative network would be developed to link different departments and agencies at State and Federal level (e.g., education, child protection, mental health, justice) and clarify roles and responsibilities, resource allocation for community-based programs, in order to provide a solid infrastructure to support mental health promotion intervention (Swan & Raphael). These recommendations remain unfulfilled in many Aboriginal communities. Hunter and Garvey (1998) noted that since the release of *Ways*

Forward, the emphasis has been on improving access to services rather than mental health promotion intervention. The (1996-2000) *Action Plan* (Social Health Working Group, 1996) proposed that mental health services and ACCHSs provide mental health promotion, however, Urbis et al. (2001) found that mental health services are not adequately resourced to provide mental health promotion programs in Aboriginal communities and these have been largely provided by other sectors and under related State and Federal initiatives.

3.5 A Whole-of-Government Approach

Pearson (2000) argued that community development for Aboriginal people must extend beyond the community to include building capacity at the socio-political level. This is imperative for Aboriginal people where governmental systems and practices have been agents for oppression and disempowerment. Prilleltensky and Nelson (1997) noted that even in Community Psychology there are few attempts to change systems at the macro level, however Cowen (2000) asserted that efforts must be targeted at the difficult to change socio-political level for meaningful empowerment of disadvantaged groups.

Government policy, services and programs have failed to improve the wellbeing of Aboriginal people and communities. Reasons for this include misguided policy, departmentalised rather than holistic framework, bureaucratic and funding inflexibility, lack of accountability, coordination and collaboration amongst government departments, agencies and Aboriginal controlled services, lack of Aboriginal self-determination and a paucity of processes to remedy these problems

(Gordon et al., 2002; NAHSWP, 1989; Pearson, 2000; Wild & Anderson, 2007). With the abolition of ATSIC in 2004, it was acknowledged that separate representation for Aboriginal people had failed and mainstream departments and agencies needed to become more accountable and accessible to Aboriginal people. It was recognised that the wellbeing of Aboriginal communities is a shared responsibility amongst individuals, families, communities and all levels of government where all parties need to work together to improve the social and emotional wellbeing of communities (Calma, 2004). Until recently, few formalised structures and processes at the political level existed to facilitate these goals.

Pearson (2000) argued that while governments are obligated to provide basic services (e.g., health, education, law enforcement) for all Australians, their role in providing programs and services, particularly in relation to social and family issues in Aboriginal communities needs to be limited to providing resources and expertise, and communities must be able to develop their own policy and initiatives in partnership with governments to tackle community problems. He proposed a partnership approach to service delivery in Aboriginal communities to establish an interface between local, State, Federal government departments and the people of Cape York Peninsula to promote coordination, cooperation and empowerment of the people (representation, increased decision making, control, responsibility, community autonomy, skill building). Part of this model included negotiation at the regional and local level about the role of the community and outsiders, use of resources, responsibility for service provision, and how best to run programs.

The mainstream sector has increasingly recognised the limitations of their approach to service delivery in Aboriginal communities (Gordon et al., 2002). In the area of mental health policy, the WA Aboriginal Suicide Prevention Steering Committee (2001) conducted consultations with Aboriginal service providers and key stakeholders during 2000 to 2001 to develop an improved approach to youth suicide prevention. Consultations identified the need for more inclusive partnerships at local and regional levels, across-agency collaboration within a holistic framework. The Aboriginal Suicide Prevention Steering Committee proposed a strategic plan to the Department of Indigenous Affairs and the WA Minister for Health in line with other National and State health, mental health and wellbeing plans/frameworks and studies (e.g., Western Australian Aboriginal Child Health Survey [WAACHS] Zubrick et al., 2005). The goals of the plan were to build partnerships at the local, regional and State level between communities and governments to promote healthy child and community development, establish common program objectives, define clear roles at all levels, reorient government policy and funding to focus on prevention and early intervention rather than tertiary intervention, pool resources from relevant agencies, up skill community people to be project officers while ensuring responses are locally controlled and implemented (Aboriginal Suicide Prevention Steering Committee, 2001). These proposed goals and strategies have also been adopted to guide social policy in WA Aboriginal affairs overseen by an Indigenous Affairs Advisory Committee (Tann, 2002). Tann pointed out that despite agreement in approach, there is no provision amongst the different policy, service delivery arms to take the lead in driving the “prevention agenda” (p. 20).

In response to the recommendations advocated by the Aboriginal and mainstream sector, the Council of Australian Governments (Australia's peak intergovernmental forum comprised of Federal, State and Territory leaders) in 2004 announced a new approach to delivery of services and programs in Aboriginal communities. A "whole-of-government approach" underpinned by the principles of collaboration, regional and local need, flexibility, accountability, leadership and the Federal Government's notion of "practical reconciliation" was recommended. This approach aims to build capacity for communities to improve outcomes for their people; build capacity of governments to work more appropriately with Aboriginal people; facilitate coordination between communities and Federal, State, local Governments and private enterprise; and spread responsibility and accountability more evenly amongst governments and communities. The approach aims to be more answerable to local need and address the lack of efficacy and under-utilisation of mainstream services as well as provide more flexibility (e.g., pooling funds for cross-agency programs).

The approach is informed top-down and bottom-up, where leadership and accountability (both Indigenous and non-Indigenous) is emphasised at the Federal, State, regional and local community level. The National Indigenous Council includes Indigenous experts who advise government on the development of policy, programs and services at Federal and State levels. In contrast with ATSIC, this body is not intended to be representative. The regional Indigenous Coordinating Centres aim to coordinate service delivery at a regional or local level. They provide communities with a single point of contact representing all key government departments and agencies (e.g., health, education, employment, housing, child and community services). Aboriginal people and communities are encouraged to develop plans for

community development with Indigenous Coordinating Centres through negotiation of “regional participation agreements” and “shared responsibility agreements” (Calma, 2004). Regional participation agreements are made with a group of communities to address government investment across a region to meet regional needs and priorities. Shared responsibility agreements are agreements between governments and Aboriginal families, communities or tribes/clans to provide resources in exchange for agreed commitments to meet objectives. Over 100 shared responsibility agreements involving 98 communities were signed by the end of 2005, predominately for infrastructure development, youth activities and training (Shared responsibility agreements and regional partnership agreements, n.d.). These agreements occur via “negotiating tables” which consist of community leaders and senior government workers. This process was first developed as part of the Cape York Partnerships scheme (Cape York Partnerships, n.d.). The process emphasises reciprocity, mutual responsibility and accountability. The community is in the position to define their priorities, the government is supposed to coordinate the resources (Eckermann et al., 2006).

Aboriginal leaders generally support the idea of shared responsibility (Eckermann et al., 2006). However, problems with mutual obligation exist where conditions of the reciprocal arrangement are imposed by governments (Pearson, 2000; Tomlinson, 2005). Overall, there is evidence of a renewed attempt by governments to make systemic changes at all levels to enable processes for empowerment/self-determination and more culturally acceptable ways of working with Aboriginal communities. However, the biggest challenge with this approach will be implementing it without compromising Aboriginal control or perpetuating

dependence (Pearson). The longer term benefits to improving outcomes for Aboriginal people and communities remain to be seen.

3.6 Summary

A review of the literature (e.g., Gordon et al., 2002; Maton, 2005; Pearson, 2000; Swan & Raphael, 1995; Trickett & Birman, 2000) suggests that interventions aimed at promoting the mental health and wellbeing of Aboriginal young people must be couched within a holistic framework that incorporates the interconnectedness of problems, their contributing factors and required solutions which are needed across many domains of living. Interventions for young people specifically are required early in their development (Tann, 2002; Zubrick et al., 2005). Interventions need to involve the whole community (Brown et al., 2002), be community-based and delivered according to a community development approach designed to strengthen capacity in young people, families, and communities (Maton, 2005). Intervention frameworks must incorporate the core principles identified in this review, such as social justice issues (e.g., equal service provision and opportunity); empowerment (e.g., self-determination, control, participation, responsibility, leadership and governance, building skills, access to resources and provision of an economic base); strengthening culture and connectedness to family, community, land (to promote identity, belonging, systems of care, social supports and healing) (Atkinson, 2002; CDHAC, 2000; Hunter, 2007; HREOC, 1997; NAHSWP, 1989; Trudgen, 2000). In order to improve the wellbeing of Aboriginal communities and build strengths, policy, services and programs require a whole-of-government approach which

ensures Aboriginal self-determination at the socio-political level and meaningful collaboration between communities and outsiders (Pearson, 2000).

CHAPTER FOUR

SERVICES AND PROGRAMS FOR PROMOTING ABORIGINAL MENTAL HEALTH AND WELLBEING

Chapter Four contains a review of mental health and wellbeing services and programs for Aboriginal people. Interventions vary widely in goals and methods and they cover the full range of approaches: Aboriginal controlled, mainstream, adapted, prevention, promotion, early intervention, community-based, community-driven and community development initiatives. It is difficult to critically review Aboriginal mental health interventions in terms of their efficacy in improving the mental health and wellbeing of Aboriginal people and communities, as very few efficacy studies have been done or results reported. The interventions are also difficult to compare due to the wide range of intervention goals, approaches and evaluation methods. Despite this, examples of services and programs are given to outline the range of approaches and types of intervention activities aimed at improving the mental health and wellbeing and building strengths in Aboriginal people and communities. Where outcome data is available, the efficacy of the intervention is reported.

4.1 Mental Health and Social and Emotional Wellbeing Services

The priorities of *Ways Forward* (Swan & Raphael, 1995) and subsequent Aboriginal mental health policies and plans (e.g., *Action Plan*: 1996-2000 [Social Health Working Group, 1996]; *Social and Emotional Wellbeing Framework*: 2004-2009 [Social Health Reference Group, 2004]) include the provision of equitable, quality

and culturally appropriate mental health and wellbeing services for Aboriginal people to improve the mental health and wellbeing of individuals and communities.

4.1.1 Aboriginal Community Controlled Health Services

It was envisaged ACCHSs would develop health services and programs managed by and for Aboriginal people in line with their priorities, needs and holistic view of health and wellbeing (Eckermann et al., 2006). At their inception Aboriginal health services survived on minimal government funding, however they presented the first alternative to mainstream health and wellbeing treatment for Aboriginal people (Eastwell, 1985). Recognising their utility, the National Aboriginal Health Strategy Working Party (NAHSWP: 1989) and Swan and Raphael (1995) recommended an increase in ACCHSs across Australia to increase Aboriginal control and provide health services to address the clinical and cultural needs of Aboriginal people. Subsequently, the National Aboriginal Community Controlled Health Organisation (NACCHO) was established with ACCHSs and Aboriginal Medical Services (AMSs) coordinated under NACCHO. ACCHSs and AMSs range from large multi-purpose services to small community-based health clinics. Most services are controlled by the local Aboriginal community; they receive government funding but operate mostly independently from government. ACCHSs aim to provide integrated primary health care, including clinical services, preventative programs, support for allied health (e.g., mental health) and staff training, advocacy and policy development (Aboriginal community controlled health services, n.d.). The *Action Plan* (Social Health Working Group, 1996) recommended the establishment of Regional Centres for Social and Emotional Wellbeing within ACCHSs. The aim of Regional Centres for Social and Emotional Wellbeing was to focus on building

infrastructure and capacity to support Aboriginal mental health service delivery, including curriculum development and training for Aboriginal Mental Health Workers (AMHWs), worker support, development of linkages with mainstream government and non-government services and undertaking data collection (Urbis, Keys & Young, 2001).

Swan and Raphael (1995) pointed out that ACCHSs provide a quality health care service for Aboriginal people in urban, rural and remote areas. Pearson (2000) stated that ACCHSs decrease dependence on non-Aboriginal systems, promote Aboriginal responsibility and participation, provide a service which is acceptable to the community, prevent paternalism and racism, promote social and cultural awareness and offer training, education and employment to Aboriginal people. Aboriginal people have gained more control at a regional level through ACCHSs and employment and training of Aboriginal Health Workers (AHWs) across Australia (Hunter, 1997). Swan and Fagan (1991) stated that while government spending has increased for ACCHSs and Aboriginal people have increased access to primary health care through such services, the positive impact of ACCHSs in terms of overall Aboriginal wellbeing is difficult to assess.

Grant, Laird and Cox (1998) explained that ACCHSs (especially their health promotion activities) survive in extremely adverse conditions including lack of funding, non-recurrent funding and criticism of the philosophy, competence and activities of these organisations. Despite this, the Kimberley Aboriginal Medical Services Council (KAMSC), like other ACCHSs, has seen continuity of staff, increasingly skilled health and mental health workers, its committee and staff able to

function in broad advisory roles at State and National levels, encouragement of innovative and culturally sensitive activities allowing scope for local development and improved acceptance of service delivery to Aboriginal people (Grant et al.)

There has been significant growth in the Aboriginal health workforce. AHWs have become an integral part of the staffing at Aboriginal health services and are seen as a hugely important factor in improving Aboriginal health, with intimate knowledge of the communities they serve, often with personal connections with that community. The NAHSWP (1989) stated that AHWs bridge the cultural divide separating Aboriginal and Western worldviews, making it easier for patients to understand their treatment and for non-Aboriginal health staff to communicate more effectively with their patients. Accredited training for AMHWs has occurred under the auspices of the Regional Centres for Social and Emotional Wellbeing, however standards vary across centres (Urbis et al., 2001). On completion of their training AMHWs are expected to have a broad knowledge-base covering treatment and prevention of health and mental health problems. These workers face enormous challenges with often unrealistic demands placed on them and difficulty working with their own families and communities, therefore more training, support and supervision is needed (Gordon, Hallahan & Henry., 2002; Trudgen, 2000; Urbis et al., 2001).

With the aim of developing a more holistic approach to service delivery, decreasing separatism and increasing Aboriginal self-determination, ACCHSs and the mainstream sector have developed collaborative partnerships with varying degrees of success. The Koori Kids Mental Health Network is a child, adolescent and family psychiatric service based at the Victorian Aboriginal Health Service in inner

Melbourne, a community health service controlled by the Victorian (Koori) Aboriginal community. Koori Kids consists of Aboriginal and non-Aboriginal mental health professionals from the Victorian Aboriginal Health Service and mainstream child and adolescent mental health services working collaboratively to address the mental health and wellbeing needs of Koori young people and their families. The collaboration began in the late 1980s and has involved numerous meetings to raise awareness amongst non-Aboriginal workers about Aboriginal history and culture, and opportunities to build trust between Aboriginal and non-Aboriginal service providers. The network aims to combine child psychiatric expertise with knowledge of Aboriginal culture in order to best treat mental ill-health in Koori families (Mushin et al., 2003). The service exemplifies a successful working partnership between mainstream mental health and Aboriginal controlled services (Urbis et al., 2001). Mushin et al. reported that significant changes have occurred in the way child psychiatric services are viewed by the Victorian Aboriginal community. Families are more able to recognise their child's mental health problems and are more open in accessing the service for help.

In northern Western Australia (WA), KAMSC Regional Centre for Social and Emotional Wellbeing has developed some partnerships with mainstream services, such as mental health workers from Northwest Mental Health Service (NWMHS) who have assisted with teaching AMHWs at KAMSC's School of Health Studies. Urbis et al. (2001) found collaboration with mainstream mental health services varied among ACCHS Regional Centres for Social and Emotional Wellbeing and they recommended the development of more formalised and outcome oriented collaborations. Some centres have since developed memorandums of understanding

(MOUs) with government services. The *Kimberley Regional Aboriginal Health Plan* (Atkinson, Bridge & Gray, 1999) recommended KAMSC develop a MOU with NWMHS. KAMSC Regional Centre for Social and Emotional Wellbeing has since forged links with NWMHS and the Kimberley Community Drug Service Team (KCDST) as part of a joint commitment to more coordinated service delivery for Kimberley Aboriginal people. After lengthy consultation, a steering committee was formed in 2002 with representatives from KAMSC, NWMHS, KCDST, Deptartment of Juvenile Justice and independent researcher Tracy Westerman to conduct the *Kimberley Regional Aboriginal Mental Health Plan* (KAMSC & Westerman, 2002). A reference group was formed to implement recommendations from the *Kimberley Regional Aboriginal Mental Health Plan*. The reference group reported to the Regional Aboriginal Health Planning Forum which is linked to State and National bodies. This aimed to improve working alliances and collaboration, and increase Aboriginal representation at the local and regional level in planning mental health services and programs for Aboriginal communities (Cheney, Milroy, Fong & Waters, 2005).

4.1.2 Mainstream Mental Health Services

The dire need for culturally appropriate mainstream mental heath services was acknowledged by the *National Aboriginal Health Strategy* (NAHSWP, 1989) and *Ways Forward* (Swan & Raphael, 1995). Dudgeon, Garvey and Pickett (2000) define "culturally appropriate" as, "the positive inclusion of and taking direction from Indigenous people and their cultures in any given issue, program, model or service" (p. 12). Mainstream mental health services still largely rely on the medical model, however they have begun to use more culturally appropriate treatment methods with

Aboriginal clientele. This has included work with Aboriginal Healers/Medicine Men, Indigenous therapies (e.g., *Ngarlu*) and adaptations of more culturally accepted mainstream therapeutic approaches such as narrative therapy, brief solution-focused therapy, rational emotive therapy and cognitive-behavioural therapy (see Clarke & Fewquandie, 1999; Gray, 1980; Koolmatrie & Williams, 2000; Roe, 2000a, 2000b; Sheldon, 2005; Vicary & Bishop, 2005; Wettinger & Westerman, 1998b). Aboriginal staff have increasingly been employed by mainstream mental health services in direct service delivery, advisory, capacity building and policy roles. Cultural awareness training is now compulsory for non-Aboriginal workers in mental health services and other mainstream agencies (Urbis et al., 2001).

In the Kimberley, NWMHS has developed innovative initiatives to enhance cultural sensitivity of service delivery. The main psychiatric inpatient facility, Graylands, is located in metropolitan Perth 2000 km away, which means individuals and carers are often separated from family and community and patients heavily sedated on plane journeys, exacerbating distress. NWMHS in conjunction with concerned Aboriginal families developed an acute residential care facility called *Mabu Maya* (Yawaru for "Good Place"). This service is attached to NWMHS to provide an alternative service to Graylands, and provides a place where a small number of families can stay with their mentally ill relative. Families learn how to care for relatives through provision of intensive mental health education while remaining connected to their families and communities. Community Elders and Traditional Healers are also encouraged to assist with treatment. Over 20 consumers and their families have received treatment at the service (Cheney et al., 2005; Urbis et al., 2001).

The “Strong Families” approach originated from recognition of entrenched barriers to achieving coordination and collaboration in the government’s delivery of “human” services and the need for a holistic framework for dealing with child and family issues (Gordon et al., 2002). Strong Families is a collaborative case management initiative for working with families experiencing social difficulties where several agencies are involved in providing assistance. The intervention model is designed to facilitate coordination among agencies and promote family empowerment through informed consent and participation in generating solutions. The intervention relies on the ability of the coordinator to be situated locally, operate independently from agencies and work flexibly. Reports to *The Gordon Inquiry* indicated that the initiative was piloted with varying levels of success in WA, limited by high staff turnover and lack of family agreement to participate (Gordon et al., 2002). The Gordon Newsletter (Department of Premier and Cabinet, 2005) updating the response to the recommendations of *The Gordon Inquiry*, revealed Strong Families’ coordinators have worked with over 80 families in WA to streamline support by working collaboratively with several government agencies. One case involved 30 representatives from 16 agencies. The initiative has reportedly been successful in maximising support for families, reducing duplication and identifying gaps in service delivery, increasing accountability of families and government agencies and creating better links among agencies.

Despite many gains, improving cultural sensitivity and access to mainstream services was still a major concern identified in the evaluation of the *Action Plan* (1996-2000) and *The Gordon Inquiry* (Gordon et al., 2002; Urbis et al., 2001). Significant challenges exist where ACCHSs and mainstream services, especially those remote,

are hugely under-resourced, under-staffed and ill-equipped to achieve the goals set out by *Ways Forward* (Swan & Raphael, 1995) and subsequent plans. *The Gordon Inquiry* (Gordon et al.) found that services are often limited to providing core business (e.g., psychiatric treatment) rather than developing linkages with other agencies, providing outreach services to remote communities, counselling, and culturally appropriate programs. Workers are overburdened with the complexities of service delivery in remote communities and there is difficulty recruiting Aboriginal staff due to competing family and community demands. Mental health and other government services are stigmatised due to historical practices making it difficult to form partnerships with the Aboriginal controlled sector and reducing access by Aboriginal people. Non-Aboriginal workers are still found to lack expertise in dealing with Aboriginal people, further reducing access for Aboriginal clientele. Hunter (2007) pointed out that there is still vast unmet need in mental health service provision for Aboriginal people, particularly in remote areas.

4.2 Mental Health and Social and Emotional Wellbeing Programs

Hunter (2004) exemplified the types of intervention for improving Aboriginal mental health and wellbeing operating at four levels. Intervention included: social justice and reconciliation at the societal level; community development and empowerment initiatives at the community level; family wellbeing and parenting programs at the family/clan level; and Indigenous therapies, adapted mainstream therapies occurring at the individual level. Some examples of these types of intervention activities are reviewed below.

4.2.1 Community Development Initiatives

Many of the efforts for prevention and promotion in Aboriginal communities have focused on youth suicide and have been funded by the Commonwealth National Youth Suicide Prevention Strategy (now termed LIFE). Urbis et al. (2001) reported that most States and Territories have developed a suicide prevention strategy. One such initiative in the Kimberley, conducted by Westerman (2002) included workshops with service providers and community people (e.g., Elders, parents, youth) from Derby and surrounding remote communities. The initiative was a response to community concern about the high rate of suicide in this region and the lack of culturally appropriate strategies to manage the problem. A community forum was held to openly discuss suicide prevention. The forum revealed major inadequacies in service provision (e.g., lack of delineation of roles and responsibilities among agencies; no group overseeing the several suicide interventions operating; poor community consultation; inadequate funding; lack of support for families; no crisis intervention or follow-up counselling and support). The need for training in suicide prevention was identified. One day workshops were held in Derby. Youth were screened using the Westerman Aboriginal Symptom Checklist for Youth (WASC-Y: Westerman, 2003). The workshops included building skills in identifying and managing risk for suicide and incorporated specific cultural risk and protective factors related to Aboriginal youth suicide. Brief counselling and debriefing was also offered as part of the intervention. Reports suggested that youth and service providers retained skills at follow-up and the intervention was highly acceptable to the Derby community (Westerman, 2002).

The “Yiriman (Youth) Project” funded under the Commonwealth Government’s “Stronger Families and Communities Strategy” was developed in 2001 to assist youth (aged 14 to 30 years) at risk of social and emotional problems (e.g., suicide, self-harm, substance abuse, offending) from remote Aboriginal communities in the Kimberley region. Elders from four language groups, Nyikina, Mangala, Karajarri and Walmajarri spaning the area from Bidyadanga south of Broome to Balgo in the southern Kimberley, developed ideas such as reuniting young people with their culture and country to improve confidence and wellbeing. These ideas were developed into the Yiriman Project which focuses on teaching young people life skills, cultural awareness, promoting strong youth leadership, support and relationship building with other language groups, land management and community development, for young people to have skills to function well in community/cultural and mainstream life. Wallace-Smith (2005) pointed out that the Yiriman Project now has a young men’s and young women’s program supported by Elders across the Kimberley. Many of the initiatives are run out of Jarlmadangah Community in the West Kimberley. The project is community-owned and driven with strong internal leadership and collaborations with outside agencies who offer education and training opportunities for young people (e.g., Kimberley Land Council; Kimberley Aboriginal Law and Culture Centre [KALACC]).

The Kullari Indigenous Women’s Aboriginal Corporation (KIWAC) was developed from the ground up, involving several Aboriginal women from remote communities in the Kullari region in the West Kimberley. KIWAC’s agenda has been to combat family violence and child abuse in communities, initially by raising community awareness. KIWAC has made connections with local agencies, such as KAMSC, the

Department for Community Development (DCD), WA Police Department and Kinway Counselling. The group successfully secured funding to provide Family Violence Workers in Aboriginal communities (DCD, 2005), however this has not yet been evaluated.

Aboriginal communities outside the Kimberley such as Yarrabah Community located in Cape York have seen a range of community-driven, community development initiatives for dealing with the high rate of suicide. In Yarrabah Community a community-driven response emerged out of disillusionment with mainstream services to address the growing suicide problem. Mainstream services and interventions were found to be reactive (often responding to crisis rather than being preventative), poorly coordinated, focused on a specific problem (e.g., violence, suicide, alcohol) rather than the interrelatedness of problems and were person-centred rather than addressing multi-levels of risk in several domains (e.g., family, community, socio-political context). Over the last decade community members in collaboration with agency service providers have identified, developed, implemented and evaluated community responses for dealing with suicide (Hunter, Tsey, Baird & Baird, 2002). Mitchell (2000) reported that the community development approach used at Yarrabah was based on a broader understanding of health which emphasised both community and individual level risk and protective factors. In addition, this approach highlighted the need for a range of activities, such as mental health education/awareness, worker training, counselling and sourcing funding to occur across the community. Hunter et al. reported that other developments operating alongside the suicide initiatives also impacted positively on community wellbeing, for example, the Yarrabah Museum opened in 1995 and provided a place where

families could learn culture and the impact of Aboriginal history. In 1997 Yarrabah Council decided to close the community Alcohol Canteen in response to concerns about the impact of alcohol on family violence and poor child care. The community development approach at Yarrabah fostered broader change beyond suicide prevention, including emphasis on community-level factors associated with risk (e.g., limiting alcohol sales), increased community responsibility and action. For example, the view that health is something that the clinic is responsible for changed to a holistic construction that located the community at the epicentre of change (Hunter et al.). From the Yarrabah experience, Mitchell concluded that ongoing engagement of community members and sustainability of interventions is more robust when activities are initiated and driven from within the community rather than by outsiders. The community moved through a series of stages from "rejection" of outside services, "commitment and collaboration" to finding solutions where community ownership of the problem took hold, and finally "persistence and planning" to build longer term structures for enhancing wellbeing (p. 18). This coincided with strengthening of the local Council and increased access to external funds, both essential for supporting the suicide initiatives.

Trudgen (2004) described a community-driven response to petrol sniffing in a remote Aboriginal community in Arnhem Land, Northern Territory. He was sent out to "fix these kids". Instead of assuming the "expert" role, Trudgen and his team of community educators/developers asked the Elders, "if 'White' people weren't here, what would you do to help your kids?" The Elders developed their own response which involved talking with the young people and asking them why they were harming themselves with sniffing. The youth spoke of their difficult family

situations, boredom and perceived lack of future. All families were consulted and the community assisted families in looking out for the young people until they could manage this themselves. The Elders took the young people back through Law. The result according to Trudgen was that the petrol sniffing problem was eradicated and the solutions were generalised to other community problems. He noted that this type of community-driven intervention "did not cost the government a cent!"

In order to tackle entrenched welfare dependence, violence, substance abuse, poor health, educational and vocational outcomes for Aboriginal people in the Cape York Peninsula, Far North Queensland, Aboriginal leaders in Cape York communities formed Cape York Partnerships (CYP) in 1999, through an agreement between the Queensland Government and regional Indigenous organisations. The ideology driving the enterprise is Director Noel Pearson's notion that Aboriginal people need the right to take responsibility to improve their own health and wellbeing, which necessitates a retreat of government directed services and programs (Pearson, 2000). CYP is a regional community development initiative operating at several levels (e.g., individual, family, community, regional, State and Federal). Initiatives are developed locally and linked regionally, and partnerships have been made with State and Federal Governments and the private sector to increase support and access to resources. As part of CYP, the "Family Development Strategy" aims to build strong families by addressing "passive welfare" by increasing economic independence (through family income management) and reducing alcoholism by engagement in "alcohol management". Education is encouraged through working with families to improve educational expectations and support for children's learning. CYP also includes "Boys from the Bush", an initiative designed for youth with substance and

or offending problems, to reorient them with cultural values and practices and teach life skills as an alternative to detention or custodial sentences. The “Work Placement Scheme”, also a youth project, places young people in mainstream employment (e.g., fruit growing) while providing ongoing support. CYP projects rely on outside volunteers to work with the communities to reach their goals (Cape York Partnerships, n.d.). Pearson (2003) stated that CYP has seen many successes, however the challenge lies in getting governments to shift away from providing services to relinquishing power and responsibility to the families and communities of Cape York.

4.2.2 Parenting and Family Wellbeing Programs

Other initiatives have focused on building skills and competence to empower Aboriginal people, in relation to parenting, coping, seeking education and vocational opportunities, increasing autonomy and control. These programs have been initiated outside communities, but have been informed by Aboriginal people. In Queensland, as part of the Resourceful Family Project, the “Indigenous Parent Program” (Clarke, Harnett & Shochet, 1999) was developed to assist parents and carers develop skills and confidence in caring for their children. This program is an adaptation of the Resourceful Adolescent Program - Parent Program (RAP-P). Indigenous RAP-P was developed in consultation with Aboriginal service providers and community members to be delivered by trained Aboriginal facilitators. The program is delivered in a community-based group format either in single one day workshops or over a series of briefer workshops. Workshops utilise group discussion, activities and video material. The program allows Aboriginal parents and carers to gain parenting and stress reduction skills to increase parenting competence and confidence. An

important component of the program is reaffirmation of existing parenting strengths and abilities (Clarke, Harnett, Atkinson & Shochet, 1999; Clarke, Harnett & Shochet, 1999). Indigenous RAP-P has been run in several Aboriginal communities in the Kimberley. The program required adaptations for different groups. Indigenous RAP-P is designed to operate under a train-the trainer model, however this has proved difficult in remote areas where skilled facilitators are scarce and workers are transient. In the Kimberley there has been difficulty sustaining the program. Clarke, Harnett, Atkinson et al. (1999) explained that the success and sustainability of Indigenous RAP-P in Aboriginal communities depends on the development of community support structures. The program coordinators have set up some community and agency support networks for training facilitators in order to promote program sustainability (Harnett, Clarke & Shochet, 2002).

An early intervention program, initiated by the Department for Community Development (DCD) has worked with Aboriginal communities and agencies in WA to deliver the "Best Start" program. The Best Start program is aimed at 0 to 5 year olds to improve their life opportunities through provision of activities that can improve health, educational opportunities, social and cultural development. This program is negotiated with the community and designed to meet the needs of that community. Best Start has operated in several remote communities and towns in WA, such as Jigalong and Carnarvon. Between April and June 2001, 770 children participated in Best Start programs (DCD Initial Submission, 5 April 2002, cited in Gordon et al., 2002, p. 136). No information on outcomes was cited in this submission.

The “Family Wellbeing (Empowerment) Program” originated to combat powerlessness, promote healing and build skills in Aboriginal people to overcome past and current effects of colonisation and assimilationist practices, create resilience and promote wellbeing (Tsey, 2000; Tsey & Every, 2000). The program, originally developed and facilitated by Adelaide based Stolen Generations survivors, is designed to enable Aboriginal people to take greater control over their own lives through understanding emotions and building coping skills such as problem solving, conflict resolution, parenting, leadership and relationship skills. Tsey, Travers et al. (2005) stated that the program aims to provide skills for Aboriginal people to engage in educational and vocational opportunities (Urbis et al., 2001). As part of the Cape York Partnerships (see below), the program was run in Yarrabah, Hopevale and Wujul Wujul Communities in Far North Queensland in conjunction with the region’s Aboriginal health services and academic institutions (e.g., University of Queensland) (Gibson, Jackson, Hall & Tsey, 2006; Tsey, Travers et al.). The program is generally delivered in a workshop format over 40 weeks for 4 hrs per week. The program is delivered in a two step participatory action research process. Step one includes personal development life skills group training. Step two involves follow-up community development aimed at supporting participating groups to collaboratively address community priorities (Gibson et al.; Tsey, Travers et al.; Tsey, Whiteside, Deemal & Gibson, 2003).

Seventeen participants were involved in the follow-up evaluation (6 to12 months after the workshops). The program was evaluated using participant observation, interviews and evaluation forms. The findings revealed three main themes: relevance; personal changes; and wider investments in the community. The initiative

was found to be highly relevant to local people due to emphasis on Aboriginal values (Tsey, Travers, et al., 2005). Results also indicated marked personal changes such as increased self-awareness and understanding of emotions, utilisation of skills in family, work and community situations (e.g., empathy, assertiveness), stronger cultural/spiritual identity and self-esteem, and enhanced ability to deal with grief and loss (Hunter et al., 2002; Tsey & Every, 2000). Participants reported that with greater personal efficacy and support from the project they went on to enact wider community change (Tsey, Travers et al.). Gibson et al. (2006) highlighted that participation in structured "empowerment" initiatives such as the Family Wellbeing Program can significantly improve participants' feelings of control and responsibility over the conditions impacting on their health and wellbeing.

The "adult" Family Wellbeing Program was adapted for remote Aboriginal school children in Cape York Peninsula to overcome bullying, fighting and low self-esteem in young people. The aims of the program are to build personal identity and awareness about children's place in the community and wider society. A pilot school-based program was delivered by visiting facilitators in twelve 1 hr sessions every 2 to 3 weeks over two school terms. Fifty 9 to 12 year olds in years 5-7 at one school and 20 students in year 7 at a second school participated in the program supported by their classroom teachers. The evaluation methodology included semi-structured qualitative interviews with students, teachers and principals designed to examine the extent to which participating in the program resulted in personal empowerment, such as enhanced analytic and problem-solving skills, self identity, empathy, increased participation in school activities, decreased bullying, teasing and fighting among students, as well as strategies to enhance sustainability of school-

based programs in remote Aboriginal communities. Outcomes described by participating students and teachers indicated that the program was highly relevant to students, enhanced student's analytical and reflective skills essential for promoting psychosocial development, increased their ability to think autonomously, resulted in less bullying at school and increased sense of identity, friendship and "social relatedness". The evaluation revealed the desire for more parent/family involvement and the coordinators are investigating sustainability strategies such as training facilitators from remote communities (Tsey, Whiteside et al., 2005, p. 112). Tsey and Every (2000) explain that empowerment programs are important to build skills increasing individual control to overcome life challenges and are effective public health strategies, however more funding is needed for Aboriginal people to design and deliver their own initiatives locally (Tsey, 2000).

4.2.3 Indigenous Therapies

As part of their research into Aboriginal violence in Queensland, Ober and Atkinson along with community representatives, formed "We-Al-Li", since partnered with Central Queensland University. The "Indigenous Therapies Program" was developed to help Aboriginal people heal from transgenerational trauma and loss (Atkinson, 1997; Clarke & Fewquandie, 1999). This approach blends Western, Eastern and Indigenous healing concepts (Atkinson). Clarke and Fewquandie spoke about "the circle", a process used traditionally by Aboriginal people to discuss tribal business. Circle work is used in the Indigenous Therapies Program. For example, people in a circle share their stories of loss, grief and trauma in a safe, egalitarian and supportive context. This promotes healing, connectedness, validation of experiences and resilience through awareness of strengths. Workshops are used to incorporate

education on mental health and wellbeing issues from an Indigenous perspective. The program also aims to build local capacity through training community workers. The Indigenous Therapies Course is a university accredited experiential course in which participants acquire therapeutic skills and participate in their own healing. We-Al-Li has delivered numerous community-based workshops in Queensland, Northern Territory and WA utilising Indigenous Therapy techniques. The authors noted that demand for Indigenous Therapies is high amongst Aboriginal communities (Clarke & Fewquandie).

Unique initiatives have been designed to enhance awareness of mental heath and wellbeing problems and facilitate healing. KAMSC Health Promotion Unit has delivered several health and mental health promotion initiatives. KAMSC in conjunction with "HEATworks" (a group of health educators/actors operating under the auspices of the Health Promotion Unit at KAMSC) have delivered health promotion messages using theatre as a counselling and problem solving tool (Urbis et al., 2001). Their mental health promotion initiative called "Moving Stories" has been performed in remote Aboriginal communities and local agencies (e.g., prison, women's refuge, schools) in the Kimberley since 1995. Moving Stories involved a form of playback theatre where the audience tells a story/problem, the actors playback the story and work with the audience to identify and consequently dramatise the audience's solutions. Emerging issues have included child abuse, family violence and alcohol-related problems. The team included a psychologist utilised for ongoing support, debriefing and crisis management for staff and audience members. Grant et al. (1998) noted that the effectiveness of Moving Stories has not been systematically evaluated, however it has been widely accepted by Aboriginal

audiences and appears to promote self and community awareness, problem solving, positive role models, and access to mental health intervention where resources are scarce. The media of art and theatre to promote mental health were found to be appropriate to Aboriginal people who favour oral and visual communication. The Moving Stories initiative has also enabled several local Aboriginal people to be up skilled in mental health issues and theatre work thus building capacity at a local level. Despite this, ongoing funding was not secured for continued operation of the project (Grant et al.).

4.3 Evaluation of Mental Health and Wellbeing Services and Programs

Evidence of best practice for promoting mental health and wellbeing in Aboriginal communities is scarce. Of the many initiatives operating in Aboriginal communities, few have been systematically evaluated or locally validated by Aboriginal people and even fewer have been evaluated long-term. Much effective work is being done at the "grass roots" level but is not officially recognised or formally reported. If evaluation research is reported, often evaluation methodology is poorly described and processes are reported more often than actual outcomes of interventions, leaving it difficult to determine the impact on Aboriginal mental health and wellbeing (Gordon et al., 2002; Mikhailovich, Morrison & Arabena, 2007). The Commonwealth Department of Health and Aged Care (CDHAC: 2000) explained that effectiveness studies are particularly difficult in Aboriginal communities where the complex inter-relationship of social, psychological and environmental factors may prolong the time taken for interventions to have effect, and external factors beyond the control of the intervention (e.g., historical factors) can impact on its overall success. The very

nature of community-based approaches where development and implementation of intervention activities emerges with community participation and collaboration over time make evaluation of such processes complex. Contextually-driven approaches do not neatly fit into the "clinical trial" model which is driven by research priorities and searches for evidence-based outcomes (Trickett & Birman, 2000). As a result, innovative interventions are omitted or not funded where evidence of best practice is not easily provided (Hawe et al. cited in Hunter & Garvey, 1998). CDHAC cautioned this will contribute to further health inequality in already disadvantaged groups.

Lack of adequately evaluated services and programs as well as under-reporting has impeded policy direction and consequently service delivery (Shannon et al., 2004). Despite the difficulties in evaluating programs (e.g., insufficient time and funding, lack of expertise, poor design, ill-defined outcome variables, culturally insensitive methods, lack of acceptance of methods), evaluation must be an integral part of intervention planning and implementation in Aboriginal communities. Tsey (2000) explained that evaluation is often "imposed" by funding providers from the top-down but evaluation needs to be directed by Aboriginal people to be of benefit. Aboriginal people require adequate resources to develop the expertise to evaluate their own projects. Evaluation methods need to be more rigorous, including concentration on outcomes as well as processes of intervention (Gordon et al., 2002; Grant et al., 1998; Gray, Sputore & Walker, 1998; Mikhailovich et al., 2007). Tsey et al. (2003) recommend that interventions in Aboriginal communities include "properly resourced longitudinal studies to increase the evidence-base for such interventions" (p. 39).

4.4 Current Challenges

There are still many barriers to Aboriginal mental health service delivery. Urbis et al. (2001) concluded that "the field is largely still in the infrastructure and capacity building stage of development so it is premature to determine whether the emotional and social wellbeing of Indigenous individuals and communities has improved" (p. 62). There have been gains in workforce development in mainstream mental health services and ACCHSs, although agreement on standards of worker training and further funding and support is required for AMHWs (Hunter, 2007), as well as additional cultural awareness training for non-Aboriginal workers. There is a need for cross-agency and cross-sectoral collaborations with mental health and other government services (e.g., housing, disabilities, child and family services, education, juvenile justice), non-government agencies and Aboriginal controlled services to provide a more holistic response to addressing problems in Aboriginal communities.

The implementation of mental health services, prevention and promotion interventions in remote Aboriginal communities is a huge challenge hampered by lack of infrastructure and resources, unmet need, vast geographical distances and dispersal of people. Services are difficult to access for Aboriginal people and service providers are under-resourced to provide the necessary level of service (Atkinson, Bridge & Gray, 1999; Hunter, 2007; KAMSC & Westerman, 2002). Skilled workers are transient and local Aboriginal workers are difficult to recruit due to additional family and community commitments. *The Gordon Inquiry* (Gordon et al., 2002) found that collaborative interagency work was beyond the workload of most ACCHSs and government workers, as were preventative and promotion efforts.

The sustainability of interventions is still a major challenge in mental health promotion and community development work, especially in remote areas (Gordon et al., 2002). Developing programs with Aboriginal communities is lengthy due to the time needed for building collaborative relationships with the local community and agencies. In many cases funding runs out before programs can have any impact. The duration of funding from State and Federal Government grants is usually 3 years with no commitment for recurrent funding. Therefore, by the time a project is established and effective links developed with the community and agencies, little time remains to actually offer any service (Cripps submission to *The Gordon Inquiry*, cited in Gordon et al., 2002). CDHAC (2000) stated that ethically, interventions need to have adequate funds available to continue them contingent on their effectiveness. Despite the call for promotion and prevention intervention over the last decade, Hunter and Garvey (1998) noted that the majority of mental health funding is ascribed to acute and chronic mental illness treatment. *The Gordon Inquiry* revealed that the bulk of intervention services and programs targeting family violence and child abuse in Aboriginal communities are directed at crisis intervention and are under-resourced to provide preventative interventions and interventions to promote the mental health and wellbeing of Aboriginal children and families (Gordon et al.). The biggest challenge to implementing mental health promotion initiatives is political will to adequately fund and support such programs in the general population and essentially in Aboriginal communities (Durlak, 2000; Hunter & Garvey).

Pearson (2003) argued for the need to step back mainstream directed services and programs to allow Aboriginal families and communities the right to take responsibility for their own heath and wellbeing. The devolution of power in the

form of policy formation, decision making, resources, control, participation and responsibility from governments and government service providers to Aboriginal families and communities remains the greatest challenge yet. The government's recent approach (introduced by the Howard Government) to service delivery in Aboriginal communities aims to address some of the identified obstacles by increasing funding flexibility, coordination and collaboration, and building capacity amongst the mainstream sector to work more appropriately with Aboriginal people and communities. The strategy encompasses changes in government structures and processes at all levels to enable Aboriginal people access to empowerment by defining their own priorities, designing, participating and managing initiatives where resource distribution and accountability is agreed by both parties. Given the extent and complexity of mental health and wellbeing problems confronting Aboriginal young people, families and communities, change is required on several fronts. Calma (2004) maintained that the lack of progress to date is not the result of a lack of solutions but a lack of taking the steps to carry out the solutions.

4.5 Conclusion

In conclusion, there exists a growing theoretical and empirical evidence-base which has enabled a more thorough understanding of the mental health and wellbeing of Aboriginal children and youth, however research in this population is still scarce (Hunter, 2007; Zubrick et al., 2005). The National Health and Medical Research Council's (NHMRC) "Roadmap" for improving Aboriginal and Torres Strait Islander health through research called for research to focus on defining factors and processes that promote resilience and wellbeing, particularly in young people (The

Aboriginal and Torres Strait Islander Research Agenda Working Group [RAWG], 2002). Zubrick et al. advocated that increasing our understanding of the risk and protective factors for mental ill-health and social and emotional problems in young Aboriginal people will enhance intervention efforts. What has been presented in this literature review is a broad generic report of problems and their antecedents. However, for effective community-based intervention to occur, information needs to be derived locally to take into account the unique experiences of Aboriginal young people, families and the community or group involved in the research. Without access to culturally sensitive and well resourced services and programs, social and emotional problems and their associated suffering won't be addressed and the cycle of problems in Aboriginal communities will continue (Memmot, Stacy, Chambers & Keys., 2001).

From a very limited base, a wide range of service and program delivery approaches stemming from the recommendations of *Ways Forward* (Swan & Raphael, 1995) have developed over the last decade. These include Aboriginal community controlled services and programs, culturally appropriate mainstream service models, workforce development, mental health promotion, prevention, early intervention, multi-level community development initiatives and Indigenous therapeutic approaches. Interventions have been undertaken by ACCHSs, government agencies and under State and Commonwealth funded initiatives. Intervention programs designed and run by outside facilitators have faced difficulty sustaining programs, especially in remote locations (Clarke, Harnett, Atkinson et al., 1999). Community-driven interventions incorporating a community development approach appear to be more sustainable. A review of interventions (e.g., Mitchell, 2000; Pearson, 2003; Tsey & Every, 2000;

Tsey, Travers et al., 2005; Trudgen, 2004; Wallace-Smith, 2005) suggests that the most acceptable and successful initiatives to combat problems and build strengths in young Aboriginal people and communities were: holistic in coverage, operating in several areas of influence; aimed to address multiple resiliency determinants (e.g., education/awareness, culture and connection to family/clan); had strong internal Aboriginal leadership; control and participation in the design and delivery of intervention activities; included building local capacity (e.g., skills, knowledge, resources, employment); encouraged collaboration with outside government agencies and the private sector, as well as regional partnerships to access expertise, resources and support. Cheers et al. (2006) concluded from their study of family violence and related problems in Ceduna Aboriginal Community South Australia, that an "innovative, holistic and multifaceted community development response" that builds on community strengths is needed (p. 59).

Amidst the challenges of intervention in Aboriginal communities, especially those remote, the review presents possible goals and methods for improving the mental health and wellbeing of remote Aboriginal young people, families and communities. Few efficacy studies have been done and more insight on culturally appropriate, effective and sustainable interventions is needed given the enormity and complexity of issues facing Aboriginal young people, families and communities.

4.6 Overview of the Current Research

The subject of this thesis is the first stage of a mental health promotion project, *Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth*, initiated

in 2001, conducted from 2002 to 2004. This project was a collaboration between the School of Psychology at Curtin University of Technology, the remote Aboriginal community of Ardyaloon, One Arm Point, and several agencies based in Broome in the West Kimberley region of WA. Funding was provided by Healthway, WA and the Australian Rotary Health Research Fund.

The research was initiated in response to the high rate of mental health and social and emotional problems in Aboriginal young people and communities in the Kimberley and the lack of effective and sustainable interventions to address such problems. This project aimed to (1) identify and explain the mental health and social and emotional problems affecting Aboriginal young people and families living in remote communities in the West Kimberley; (2) identify and describe culturally sensitive mental health promotion interventions for young people and families living in remote communities; and (3) culturally validate the research findings and methodology. The overriding goal of the current research was to work with Ardyaloon Community to prioritise and define solutions to youth problems, in order to build strengths and promote youth and community wellbeing. The research included three main phases, although processes and methods overlapped and some were ongoing for the duration of the project.

Phase One (2002) was characterised by formative preparation which involved extensive consultation, including scoping local issues, formulating project objectives according to local priorities, and establishing working relationships with key stakeholders.

Phase Two (2003) included consolidating research partnerships and ethics agreements, collaborative development of research questions, methods and interview material, as well as two rounds of data collection which involved interviews and discussion groups in Broome and One Arm Point (Study 1: *Problems, Risk and Strengths* and Study 2: *Community Solutions*).

Phase Three (2004) involved the research feedback and cultural validation process (Study 3: *Feedback and Validation of the Research Findings*). This phase also included more intensive data analysis and formulation of a model for community-based mental health promotion intervention with remote Aboriginal youth and communities, in particular Ardyaloon Community.

SECTION TWO:

METHODOLOGY

CHAPTER FIVE

RATIONALE FOR THE METHODOLOGY

5.1 Pitfalls, Values and Ethics in Research with Aboriginal Communities

Indigenous people perceive themselves to be the most researched peoples on the planet (H. Councillor, personal communication, April 2002; Smith, 2005). Research, like other interventions in Aboriginal communities, has long had a poor reputation. Hunter (1997) pointed out that in early mental health research, remote Aboriginal communities served as an "Aboriginal mental health laboratory" (p. 822). The goals and methods of research were developed from a Western rather than Indigenous perspective, failing to account for cultural difference. Research was directed by non-Aboriginal people, imposed on Aboriginal communities, with little consultation, community involvement or feedback of information to participants (Hunter, 1992b; Smith, 1999). Indigenous perspectives and knowledge have been ignored, simplified or subjugated in research conducted by outsiders (Fielder, Roberts & Abdullah, 2000). Research has largely failed to address concerns or provide benefit to Aboriginal people and communities (Humphery, 2001; National Aboriginal Health Strategy Working Party [NAHSWP], 1989). Overall, researchers and research have been seen as tools of colonisation and oppression rather than self-determination and change for Indigenous people, resulting in a profound mistrust of non-Indigenous research and researchers (Humphery, 2001; National Health and Medical Research Council [NHMRC], 2003; Smith, 1999, 2005). Therefore, for the current research it

was essential to utilise an approach and methods which constituted “culturally safe” research (Atkinson, 2002).

Over the last few decades much debate and theorising, both within and outside the Aboriginal community, has focused on what defines culturally appropriate and effective research for and with Aboriginal people. Burchill (2004) asserted that research is not the answer to all of the issues facing Aboriginal communities but it can assist to generate change, reveal issues and strengths, formulate strategies for development and have political influence. The approach and methods of the current research were holistic and multidisciplinary (Browne, Dzidic & Bishop, 2005), informed by qualitative inquiry, Indigenous research and Community Psychology principles and practices, as well as the values and ethics outlined in guidelines pertaining to research with Aboriginal and Torres Strait Islander peoples (e.g., NHMRC, 1991, 2003; Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2000).

More recently, Indigenous people have rejected involvement in research directed by outsiders and developed their own research agendas and methodologies, contributing to the expanding field of Indigenous research (Humphery, 2001; Smith 1999, 2005). Indigenous research developed in the context of the wider political struggle for Indigenous self-determination and empowerment and to challenge traditional approaches to research (Bishop, 2005; Smith, 2005). Indigenous research “privileges Indigenous concerns, Indigenous practices and Indigenous participation as researchers and researched” (Smith, 1999, p. 107). Central to this approach, is “Indigenous peoples’ inherent right to self-determination, and to control and

maintain their culture and heritage" (AIATSIS, 2000, p. 1). Smith (1999, 2005) explained that the Indigenous research agenda is to "decolonise" research practices by redressing the power imbalance, reclaiming and fostering cultural values, knowledge, beliefs and practices and building capacity in Indigenous communities and researchers. The primary goal of Indigenous research is self-determination, involving "processes of transformation, of decolonisation, of healing and of mobilisation as peoples" (Smith, 1999, p. 116). Moreover, research should extend beyond culturally sensitive and empathic approaches to addressing the problems in Indigenous communities and generating change. Smith explained that Indigenous methodologies are an amalgamation of existing (Western/academic) methodological approaches (e.g., qualitative research) and Indigenous ways of knowing and being.

Sonn and Bishop (2000) argued that Community Psychology is a useful framework for working with Indigenous communities. Community Psychology views things holistically, with an understanding of the person-in-context and the impact of social, political, and cultural forces on the individual and community. The theoretical and practical assumptions underlying Community Psychology are: cultures have their own set of values and views of the world; the world is socially constructed; the individual cannot be separated from their social and cultural context and are thus affected by the systems they operate in. Community Psychology focuses on the study of "process" rather than just "outcomes". It is primarily concerned with "transforming existing oppressive social arrangements and the redistribution of resources to give people control over their lives to determine their own futures" (Sonn & Bishop, p. 297). Prilleltensky and Nelson (1997) summarised the values underpinning Community Psychology: "health, caring and compassion, self-

determination and participation, human diversity, and social justice" (p. 167). Such principles, practices and values parallel those articulated in Indigenous research.

In a step to address the failures of research in Indigenous contexts and formalise culturally sensitive goals and methods of research, the NHMRC produced the (1991) *Interim Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research*. The 1991 *Guidelines* emphasised Indigenous control, consultation, community involvement and the importance of feedback (Humphery, 2001; Hunter, 1992b), but were viewed as conceptually and practically limiting, encouraging adherence to rules rather than reconceptualising the approach to research with Indigenous people (Humphery, 2001). Humphery argued that there was a lack of information in the *Guidelines* on how processes such as consultation should be carried out. Furthermore, goals such as Aboriginal control of funding and publications were not included. The 1991 *Guidelines* was revised and replaced with the NHMRC (2003) *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. The 2003 *Guidelines* moved beyond rules of ethical conduct to define core Aboriginal and Torres Strait Islander values to incorporate in research design and conduct (NHMRC, 2003). The *Guidelines* aim to increase cultural awareness, understanding and incorporation of cultural difference into research with Indigenous people. Furthermore, to improve the ethics, quality and outcomes of research, eliminate culturally inappropriate interaction and promote Indigenous values and experiences (NHMRC, 2003). The values defined in the *Guidelines* are "Spirit and Integrity", "Reciprocity", "Respect", "Equality", "Survival and Protection", and "Responsibility" (p. 8). For Indigenous people, values for ethical conduct in research are based on the same values which govern

relationships with one another and with the environment (Smith, 1999). Below is a summary of the six core values and examples of how each value can be demonstrated in research with Aboriginal individuals, communities and Aboriginal directed Human Research Ethics Committees as articulated in the 2003 (*NHMRC) Guidelines*.

Reciprocity

"implies inclusion and means recognising partners' contributions, and ensuring that research outcomes include equitable benefits of value to Aboriginal and Torres Strait Islander communities or individuals" (p. 10).

Research(ers) -

- Recognise contribution.
- Provide equal benefit to individuals and communities where benefit is defined and valued by the community and contributes to cohesion and survival.
- Contribute to the improvement of health and wellbeing of participants and communities.
- Respond to community need.
- Build capacity (e.g., skills development) in the community and or at a wider political level.
- Modify the research in line with community values and aspirations.
- Engage with Human Research Ethics Committees in a meaningful way.

Respect

"Respectful research relationships acknowledge and affirm the right of people to have different values, norms and aspirations" (p. 11).

Research(ers) -

- Foster trusting, meaningful research relationships.
- Engage Aboriginal controlled institutional structures as part of consultation, negotiation, seeking ethics approval.
- Feed back to participants and community as a priority before publications.
- Feed back research information in an appropriate and understandable way.
- Make agreements about when, how and who will engage in the research process at the outset of the research.
- Make agreements about ownership, rights of access to Aboriginal people's intellectual property, management of data, publications, protection of individual and community identity, through engagement of community's values and processes until they are satisfied with the agreements.
- Respond to diversity in communities or groups, particularly in terms of how decisions are made.
- Acknowledge individual and collective contributions.
- Acknowledge and affirm the right of people to have different values, norms and aspirations.

- Minimise the impact of “difference blindness” at all stages of the research process (p. 12).
- Consider the consequences of research practices.

Equality

Involves “valuing knowledge and wisdom”, the “equality of partners” and “distribution of benefit” (p. 15).

Research(ers) -

- Show equality in the way communities are included in the research.
- Make strong agreements which sustain equality.
- Ensure the participating communities understand and are satisfied with the research, the benefits it offers and how these are distributed.

Responsibility

Research(ers) -

- Do no harm to individuals or communities or the things they value.
- Ensure accountability to individuals, families and communities.
- Exchange research information, negotiate in a transparent manner.
- Processes need to be reviewed by the participating community and Human Research Ethics Committee to minimise any unforseen consequences.
- Ensure feedback is timely, relevant to the concerns, values and expectations of participants and the community.
- Make clear the demand on partners and the implications of demands.

Survival and Protection

Implies the importance of values shared amongst Aboriginal and Torres Strait Islander Peoples, respect for social cohesion and cultural distinctiveness.

Research(ers) -

- Contribute to the maintenance of social and cultural bonds amongst family and community.
- Do not discriminate against individuals or groups, or erode culture.
- Respect the values and identity (individual and collective) of people and communities.
- Encourage cultural distinctiveness and eliminate any threats to this.

Spirit and Integrity

"This is an overarching value that binds all others into a coherent whole" (p. 19). This value is about continuity of past, present and future generations, as well as actions which maintain the coherence of values and cultures.

Research(ers) -

- Demonstrate credibility in intent and process.
- Recognise diversity of Aboriginal peoples' cultures and ways communities reach decisions.
- Show personal integrity and "a commitment to working within the spirit and integrity of Aboriginal and Torres Strait Islander Peoples" (p. 20). (NHMRC, 2003).

The NHMRC (2003) stated that the ultimate success of research carried out in Aboriginal communities depends on the trustworthiness of the research and the researchers. Building trust is not just adherence to ethical rules, rather trust comes from working with the core values and principles pertaining to Aboriginal culture and experience. To summarise, for Indigenous communities, research ethics is fundamentally about establishing and maintaining respectful and reciprocal relationships with individuals, groups and communities (Smith, 1999, p. 97).

5.2 Approach to the Current Research

The approach to the current research was informed by principles from Western research (e.g., qualitative inquiry, participatory action oriented research), and Indigenous research and ethics. Browne et al. (2005) stated that multidisciplinary approaches allow a holistic conceptualisation of problems and aid in the formulation of interventions and solutions in settings characterised by complex problems. Smith (2005) stated that "qualitative research is an important tool for Indigenous communities" (p. 103) as it creates the space to make sense of complex and changing realities, has the potential to respond to epistemic challenges, to understand social life, and the large and small changes that affect people's lives. Qualitative research studies the person in context, locating the research in the social, cultural, historical and political reality of participants (Denzin & Lincoln, 2005; Patton, 2002). The researcher becomes immersed in the worldview of the participants and community. In this approach research information is gathered and knowledge developed in an iterative-generative-reflective process that encourages community participation,

ownership and direction of the research project (Bishop, Sonn, Drew & Contos, 2002).

Qualitative research has no theory or paradigm strictly its own and does not privilege one specific method or practice over others. Rather, the field of qualitative inquiry cuts across disciplines, allowing the research to be informed by several disciplines and modes of practice (Denzin & Lincoln, 2000, 2005). Qualitative research is an interpretative, naturalist inquiry where researchers make sense of people's experiences and the meanings they bring to them, using an array of methods or inventing new tools or techniques according to what fits the context (Denzin & Lincoln, 1998, 2005). Morse and Field (1996) argued that it is impossible to develop a rigid procedure for carrying out qualitative research and hypotheses are not formalised prior to the study. Instead, the researcher has guiding questions which are modified and new questions are generated in the field. The approach is flexible enough to make modifications and to allow the research to emerge as part of the research process (Rossman & Rallis, 1998; Taylor & Bogdan, 1998). Qualitative research is concerned with in-depth inquiry which means relatively small sample sizes. Individuals, communities or organisations are involved in qualitative research due to their insight into the phenomenon under investigation (Patton, 2002).

A qualitative approach lends itself well to the current research due to the holistic, naturalistic and contextual nature of qualitative inquiry, as well as the flexibility and emergent nature of the approach and methods (Morse & Field, 1996). The aims and methods can be derived in consultation with the community and other key stakeholders, in line with community aspirations and priorities (Holmes, Stewart,

Garrow, Anderson & Thorpe, 2002). A qualitative approach allows the research and researcher to be socially responsive, enabling opportunities for empowerment and social change (Rappaport, 1994). Prilleltensky and Nelson (1997) highlighted that participant-driven research, "which examines processes and outcomes at multiple levels of analysis, will not fit neatly into experimental or quasi-experimental designs" (p. 182). Previous research conducted in Aboriginal communities in the Kimberley region of Western Australia (WA) (e.g., Vicary, 2002) employed qualitative inquiry as opposed to quantitative or survey research as the approach most favoured by the Aboriginal Steering Committee and participants.

In relation to the current research, the qualitative approach was community-based, participatory and action oriented, an integrated approach which has shown utility in Indigenous research contexts (Atkinson, 2002; Smith, 1999). Kemmis and McTaggart (2005) characterised participatory research by "shared ownership of research projects, community-based analysis of social problems, and an orientation toward community action" (p. 560). Participatory research encourages collaboration, power sharing and skills development (Patton, 2002). Patton explained that "people who participate in creating something tend to feel more ownership of what they have created and make more use of it" (p. 184). Action research in Indigenous communities aims to bring about positive change in people's lives where local people generate local solutions to local problems (Smith, 1999). Fielder et al. (2000) asserted that a community-based participatory approach involves Indigenous people as equal participants where their interests (not the researchers) are of primary concern. Bishop (2005) highlighted that "the research process is participatory as well

as *participant driven*" (p. 120), therefore, the research can not proceed without the involvement of the people.

In summary, the current research utilised a holistic methodological approach (Browne et al., 2005) which was multifaceted: namely qualitative, participatory and action oriented, community-based and locally driven, with an emphasis on Aboriginal values and cultural safety in research, as well as empowerment and social change. The approach relied on specific characteristics, roles and responsibilities of the researchers.

5.3 Role of the (non-Aboriginal) Researcher in Aboriginal Research

The role of the researcher is vitally important in working with Aboriginal communities where culturally inappropriate and unethical conduct of non-Aboriginal people has contributed to disempowerment and lack of engagement of Aboriginal people in research and services (Trudgen, 2000; Vicary & Andrews, 2001). In a qualitative approach, the researcher's personal experiences, insights and understanding shape the inquiry (Patton, 2002). Data are filtered and interpreted through the worldview of the researcher (Rossman & Rallis, 1998). Qualitative inquiry "calls on the researcher to be pragmatic, flexible, politically aware, and self-reflective" (Rossman & Rallis, p. 10). The researcher must have deep interpersonal and emotional sensitivity, perseverance, self-discipline and the ability to work across disciplines within and between a multiple of perspectives (Denzin & Lincoln, 2005; Rossman & Rallis). In a participatory approach researchers are equal to participants.

Researchers take on the role of facilitator and collaborator, operating as a learning resource (Patton).

Bishop et al. (2002) found that in research in Australian Aboriginal communities the role of the researcher is negotiated as part of the early consultation phase. Smith (2005) stated that building, maintaining, nurturing relationships and strengthening connectivity are important research skills in an Indigenous research context. Getting to know the Aboriginal community involves understanding identity and diversity, the importance of history, traditions and culture, family and social structures and following correct protocols of engagement (Burchill, 2004). The NHMRC (2003) advocates that researchers "need to demonstrate through ethical negotiation, conduct and dissemination of research that they are trustworthy and will not repeat the mistakes of the past" (p. 18). Trust can be built through many personal interactions, however it can be eroded by subtle and sometimes subconscious encroachments on Aboriginal people's values and principles (NHMRC). One of the criticisms most often cited by Aboriginal people is that outsiders do not take enough time to build relationships and develop trust (Burchill; Gordon, Hallahan & Henry, 2002).

Atkinson (2002) explained that researchers need to understand and respond to "the potential for the intentional or unintentional misuse of power in the relationship between the researcher and the researched" (p. 14). Atkinson and others (e.g., Bishop, 2005; Smith, 1999, 2005) conceded that empowering and ethical relationships in research are based on reciprocity and respect as defined by the Indigenous people involved and this needs to be demonstrated in all stages of the research. The power imbalance can be addressed and self-determination

operationalised in the context of research relationships through utilising Indigenous cultural aspirations, understandings and practices in formulating research processes (Bishop).

Vicary and Andrews (2001) acknowledged that no-one can ever be fully competent in understanding the worldview of another culture unfamiliar to their own. Training in cultural awareness prior to entering another culture can significantly increase non-Aboriginal people's awareness and understanding of Aboriginal cultures and experiences (Vicary & Bishop, 2005). Ranzijn, McConnochie, Nolan and Day (2007) define cultural competence as "the ability to work effectively in Indigenous contexts" (p. 10). Swan and Fagan (1991) and others (e.g., Burke, 2007; Gordon et al., 2002; Human Rights and Equal Opportunity Commission [HREOC], 1997; Kimberley Aboriginal Medical Services Council [KAMSC] & Westerman, 2002; Swan & Raphael, 1995) outlined the knowledge areas non-Aboriginal workers require to work effectively with Aboriginal people and communities, as follows:

- Aboriginal history.
- The nature and causes of mental health and wellbeing problems in Aboriginal communities.
- The impact of colonisation and consequences of rapid socioeconomic change on Aboriginal people.
- Aboriginal cultural values and variation in communication.
- Aboriginal attitudes and beliefs about health and healing.
- The barriers to accessing mainstream mental health services and programs.

- Aboriginal community control and empowerment.
- The role of Aboriginal Health Workers (AHWs) and how to work with them.

Trudgen (2004) asserted that the most influential cultural awareness training is localised, and involves spending time in the community, listening and talking with local Aboriginal people, learning the language, understanding the kinship system and avoidance relationships. This knowledge and experience reduces the likelihood of non-Aboriginal people enacting colonising roles, and further traumatisation of Aboriginal people (Atkinson, 2002; Trudgen, 2000).

Researchers must be aware that the relationships and research processes are shaped by their own histories, gender, class, race and ethnic orientation and they need to develop an acute awareness of their worldview and how this impacts on the research (Denzin & Lincoln, 2005; Rossman & Rallis, 1998). Rossman and Rallis explained that data are filtered and interpreted through the worldview of the researcher. “It is crucial, therefore, that researchers develop an acute sensitivity to who they are in their work” (Rossman & Rallis, p. 26). Qualitative researchers and writers in the Indigenous domain have advocated the need for researchers to engage in reflexivity or “reflective practice”. Walker, McPhee and Osborne (2000) argued that critical reflection is an important process to ensure that work is both culturally sensitive and effective. Reflective practice in an Indigenous context is about analysing the broader historical, cultural, social, political, and economic context, how it impacts on professional and personal practice, how one can reflect on what works and what doesn’t, and how this work can be improved. Critical reflection can be a tool for

generating knowledge and processes and in turn promoting social justice for Indigenous people and enhancing professional competence of non-Aboriginal people (Walker et al.). This process involves self-reflection on who we are and what we bring to working with Indigenous people. Walker et al. suggest some strategies for reflection, including asking questions, analysing, finding alternate ways to define a problem or concern, seeking many perspectives through reading, talking with key people, taking on the perspective of others (empathising), talking things over with a mentor, recording observations and reporting.

The participatory approach relies on immersion of researchers in the field, often for long periods of time. Bishop et al. (2002) reflected that working in Aboriginal communities is challenging. Researchers must tolerate a degree of ambiguity and this can cause strain. Fielder et al. (2000) explained that researchers must deal with "the politics of research" with Aboriginal people, including the legacy of history which has contributed to "distrust, anger, cynicism, fear and disengagement" (p. 353). Furthermore, non-Aboriginal people working with Aboriginal communities should question their motives and address any anxieties that may arise (Trudgen, 2000; Vicary & Andrews, 2001). Westerman (2004) recommends that non-Aboriginal people working with Aboriginal people and communities engage in cultural supervision from a suitably experienced person to facilitate reflection, enhance cultural learning and seek ongoing support.

5.4 Methods for Consultation, Engagement and Capacity Building

5.4.1 Consultation and Engagement

Consultation is an ethical responsibility of the researchers in conducting research with Indigenous communities (AIATSIS, 2000). The AIATSIS stipulated that "at every stage, research with and about Indigenous people must be founded on a process of meaningful engagement and reciprocity between the researcher and the Indigenous people" (p. 1). Preliminary consultation involves an "honest exchange of information about aims, methods and potential outcomes (for all parties)" (p. 2). The goal is that individuals and communities have a clear understanding of who the researchers and other stakeholders are, their institutional or organisational affiliation, and funding support. The community/stakeholders and researchers should achieve a shared understanding and formal agreement about the proposed research, including the research intentions, methodology, ethical considerations and expected outcomes. Where practical a "protocol" or "memorandum of understanding" should be the end result of the initial consultation and negotiation process.

AIATSIS (2000) suggested strategies for consultation, such as firstly identifying individuals, communities and organisations to be involved in consultations. Burchill (2004) cautioned researchers to consult widely and not listen to just those with "strong voices who set the agendas" (p. 9), as those agendas are not always what the rest of the community want or need. Crawford (1989) recommended that when working with Aboriginal communities researchers work with the community as a whole, showing respect for existing social and political (power) structures and involving the whole community in consultation and major decision making not just

individuals. Crawford suggested a participatory, not controlling role in discussions. Outsiders should not claim to have all the answers but be prepared to help find them through listening, negotiating and exploring issues with the people involved (Sonn & Bishop, 2000). Crawford, Dudgeon, Garvey and Pickett (2000) outlined the distinction between conducting meetings and decision making in Western and Aboriginal contexts. Non-Aboriginal people are more likely to keep a meeting or discussion to an agenda and time schedule, whereas Aboriginal people generally allow meetings to take their own course and pace. The authors pointed out that decisions are made by community consideration and consensus not by individuals, therefore researchers need to consult and engage many people in the decision making process. In general, disagreement is passive in contrast to Western styles of debate and outward disagreement (Crawford et al.).

Wettinger and Westerman (1998b) advised that when establishing rapport with remote Aboriginal communities it is important to spend time becoming familiar with the community. For example, find out who the chairperson, councillors, community health nurse, teachers are and ask to meet with these people; notify the community of visits and meetings in advance, usually in writing; seek information from community advisors or cultural consultants about what is happening in the community (e.g., cultural practices, funerals). The AIATSIS (2000) also gave some practical suggestions, such as obtaining permission to visit the community for the time needed to carry out the research and feed back results, communicate in face to face discussions, explain the benefits of the research without overstating them, and most importantly allow enough time for discussion and community consideration of research material. The authors highlighted that the consultation process is ongoing,

allowing the community continued consideration and meaningful engagement in all stages of the research process, including reporting back results and discussing publications.

Several authors have cited the benefit of forming a steering committee or reference group consisting of key Aboriginal people to advise on cultural aspects, guide the formulation and direction of the research and increase engagement with and ownership by Aboriginal people (Bishop, Vicary, Andrews & Pearson, 2006; Fielder et al., 2000). Steering committee members are best identified in formative consultation, individuals must be willing to participate, representative of study participants, respected by their community and fully informed about their involvement (Bishop et al.). Mikhailovich, Morrison and Arabena (2007) conducted a review of health promotion intervention evaluation studies carried out in Aboriginal communities reported from 2000 to 2005. The authors concluded that the establishment of steering or reference groups led by community members and participants was a critical factor in the efficacy of the program. Bishop et al. noted that steering committee members are able to "vouch" for researchers by conveying positive information about the researchers and research, which may help build trust in the research(ers) and increase community participation.

It is strongly advocated in the mental health field and elsewhere that engagement of Aboriginal people as cultural consultants is essential to provide information and cultural expertise to non-Aboriginal people working with Aboriginal individuals and communities (Sheldon, 2001, 2005; Vicary & Bishop, 2005; Vicary & Westerman, 2004). Cultural consultants can help bridge the gap between non-Aboriginal and

Aboriginal beliefs pertaining to Aboriginal mental health and include in this understanding the socio-historical and cultural experiences of Aboriginal people. Westerman (2004) asserted that working with cultural consultants should become standard practice when providing services for and with Aboriginal clientele. Cultural consultants are usually respected members of the community selected by the community or client to guide the clinician or researcher in gaining a culturally appropriate conceptualisation of the problem at hand (Vicary & Bishop, 2005; Westerman, 2004). Bishop et al. (2006) suggested engaging cultural consultants early in the research process in an equal partnership. In his research in the Kimberley region, Vicary (2002) found having people in the community whom the researchers could contact prior to visits assisted in checking on local events (e.g., funerals), cultural practices (e.g., Law business) and to arrange suitable days and times to visit the community (Vicary & Bishop).

Vicary and Bishop (2005) outlined a model of engagement aimed to better prepare non-Aboriginal workers to work more successfully with Aboriginal people and communities. The model summarises some of the methods outlined above: building a solid relationship with the community through a "relationship engagement phase", including (a) researching the local Aboriginal community; (b) developing networks and relationships; (c) non-judgmental self reflective practice; and (d) modification/adaptation of engagement skills (p. 14).

5.4.2 Capacity Building

A key component of effective and ethical Aboriginal research is the employment of Aboriginal people, or skills transfer in all facets of the research process (Social

Health Reference Group, 2004). The AIATSIS (2000) recommended finding out at the outset what the community's needs are in terms of community involvement and capacity building. Smith (2005) suggested some strategies for building research capacity in Indigenous communities. These include: the employment and training of Indigenous people as researchers; participation of Indigenous people in a range of research projects; the generating of research questions by communities; developing Indigenous research methodologies; developing research protocols for working with communities; engagement and dialogue between Indigenous and non-Indigenous researchers and communities (p. 92).

Many of the approaches to research assume direction from Indigenous people. Smith (1999) explained that with few trained Indigenous researchers, non-Indigenous people can mentor Indigenous researchers, providing guidance, training and support through collaborative partnerships. Crawford et al. (2000) stated, "don't make yourself indispensable. Rather, train Aboriginal people alongside you" (p. 191). Community members can be encouraged to be involved in the research as collaborators, advisors or helpers. People need to be paid for their assistance, especially when time is given above normal personal or community commitments (AIATSIS, 2000; Fielder et al., 2000).

Sonn and Bishop (2000) discussed their experience carrying out research with a Kimberley Aboriginal community. The authors explained that the use of a critical reference group consisting of Aboriginal and non-Aboriginal people enabled capacity building and empowerment utilising a collaborative approach with guidance from Aboriginal people involved in the study. The success of the project was measured in

terms of the capacity of the community to take on the roles of the outside researchers and control the project. Overall, collaborative approaches are empowering where researchers work in equal partnerships with the community to create or obtain resources and build skills (Rappaport, 1994).

5.5 Methods for Information Sharing, Recording and Analysis

5.5.1 Cross-cultural Communication

Trudgen (2000) argued that social and emotional problems, including loss of control and lack of empowerment experienced by Aboriginal people, can be attributed to inadequate interaction with the dominant culture characterised by poor cross-cultural communication. Feelings of mistrust, invalidation and alienation are experienced by Aboriginal people in contact with the dominant culture when communication is ineffective. The narrative method that focuses on circular communication (e.g., story telling) as opposed to more direct communication (e.g., question-answer driven) is cited to be the most acceptable and effective style of communication with Aboriginal people.

A fundamental communication style used by Aboriginal people is “yarning”. Yarning requires a relaxed context, empathic listeners and no set agenda (Gilchrist et al., 2002). Trudgen (2000) emphasised that the overarching goal of communication with Aboriginal people is relationship building, seeking mutual trust and a shared understanding. “For Aboriginal people, information gathering is an exchange process” (p. 91). Information is gathered as part of a continual reciprocal relationship and is about building relationships (Donovan & Spark, 1997). Similarly, Gilchrist et

al. asserted that yarning as a way of sharing information fosters connection and relationship.

Trudgen (2000) suggested that the non-Aboriginal person take on the “child” role when communicating with Aboriginal people, listening, learning, seeking guidance, allowing the Aboriginal person to enact the role of the “parent” imparting their knowledge, wisdom and experience. Eckermann et al. (2006) stressed that in interactions with Aboriginal people, non-Aboriginal people must empathise rather than sympathise, with sympathy comes pity, with empathy comes understanding. Trudgen (2000, 2004) and others (Burchill, 2004; Crawford et al., 2000; Donovan & Spark, 1997; Dudgeon, 2000b; Ekermann et al., 2006; Wettinger & Westerman, 1998a) outline some useful cross-cultural communication strategies with remote Aboriginal people, as follows:

- Do not assume the role of the expert.
- Understand the worldview of another – understanding things from another’s perspective even if it doesn’t make sense to you.
- Find a place to talk deemed suitable by the Aboriginal person, e.g., outside the office.
- With individuals sit side by side, direct eye contact can be confrontational.
- With a group or family sit with the group in a circle, this signifies members are equal.
- Don’t single out people in a group. Ask questions to the whole group.

- Engage in circular not linear dialogue – e.g., yarning - listen, don't interrupt or summarise as the point may be made at the end of the yarn.
- Avoid "high talk" (technical jargon), talk plainly and clearly.
- Allow time to reflect on what is discussed.
- Accept silence – Aboriginal people are raised to think before they speak.
- Direct, closed questions may result in a forced "yes" response.
- Avoid negative or double barrel questions.
- Don't "name-drop".
- Expect passive rather than overt disagreement.
- Seek permission to ask direct questions or when more personal information is required.
- Use pictorial representations where applicable to aid in understanding.
- Define time according to known events, e.g., in the morning, wet season.
- Be aware of symptoms of "shame" and address these respectfully without judgment.
- Build on the people's knowledge base from known to unknown.
- Understand Kriol (Aboriginal English), e.g., "biggest mob", "shame".
- Know and respect the boundaries between women's and men's business, kinship and family relationships, avoidance relationships.
- Use interpreters where English is a second or third language. Interpreters should be chosen by the community.

In addition to already discussed "ways of working" with Aboriginal individuals and communities, the current research employed several qualitative data gathering methods as follows.

5.5.2 Participant Observation

Taylor and Bogdan (1998) argued the strength of participant observation, in that "no other method can provide the depth of understanding that comes from directly observing people and listening to what they have to say at the scene" (p. 90). Morse and Field (1996) explained that "observations focus on the context and include the reactions of individuals in the social setting and the structural-functional aspects of the society being studied" (p. 87). Rossman and Rallis (1998) noted that observation aids in the understanding of the complexity of the social setting. The researcher must observe themselves and others and interactions of the self with others (Patton, 2002). The advantage of participant observation is that the researchers can immerse themselves in the field in order to understand the complexities of the community, participate in community life while recording events and increasing opportunity for interaction and relationship building (Morse & Field).

5.5.3 Interviews and Discussion (Focus) Groups

The most common data gathering technique in qualitative research is interviews. Interviews are useful because the interview enables the researcher to obtain the required information while allowing the participant to freely describe their story (Morse & Field, 1996). Taylor and Bogdan (1998) asserted:

> By virtue of being interviewed, people develop new insights and understandings of their experiences. They may not have thought about or reflected on events in which the interviewer is interested, and even if they have, they interpret things a bit differently each time (p. 98).

Rossman and Rallis (1998) explained that "people make meaning of their lived experiences by narrating those experiences" (p. 185). In addition, Morse and Field (1996) pointed out that the interview may be a cathartic and therapeutic experience for participants. Atkinson (2002) found using interviews with Aboriginal people facilitated personal growth and healing in respondents.

This study used the semi-structured interview. Kvale (1996) explained that the semi-structured interview has certain themes to be covered along with questions, yet "there is an openness to changes of sequence and forms of questions in order to follow up the answers given and the stories told by the subjects" (p. 124). For semi-structured interviews the interview guide contains an outline of topics to be covered and suggested questions (Rossman & Rallis, 1998). With a semi-structured format, interviewees answer the same questions allowing comparisons of responses (Patton, 2002). Vicary (2002) found semi-structured interviews acceptable and useful in his research with Aboriginal people in the Kimberley. He termed this method the "semi-structured yarn".

Discussion or focus groups were also used in data collection. The focus group interview provides the opportunity for participants to consider their own views in the context of the views of others (Patton, 2002). Group interviews encourage discussion and expression of differing points of view (Rossman & Rallis, 1998). In group interviews the researcher must act as a group facilitator and moderator, managing interactions between members of the group (Taylor & Bogdan, 1998). The use of discussion groups is beneficial in that attitudes and perceptions are not generated in isolation but via interaction with others (Morse & Field, 1996). As Rossman and

Rallis pointed out, the interaction of participants is the key to focus group interviewing whereby "people often need to listen to others' opinions and understandings to clarify their own" (p. 135). Focus groups can also be used to ascertain consistency or diversity in responses (Patton). Members of the focus group are selected because they are knowledgeable about the topic under investigation; the group is fairly homogenous in order to encourage sharing of views and opinions (Morse & Field).

In conducting interviews within Aboriginal communities, Donovan and Spark (1997) suggested that it is best to use interviewers, either Aboriginal or non-Aboriginal, who have ongoing relationships with the respondents as Aboriginal people view information gathering and giving as a shared experience about building a relationship over time. Generally, it is better to use interviewers who are the same sex and age as interviewees (Donovan & Spark). Patton (2002) stated that having more than one interviewer "reduces interviewer effects and bias" (p. 349).

5.5.4 Field Notes and Reports

The goal of the qualitative researcher is to describe and record the lived experience of participants and their community. Field notes are written descriptions of what is happening in the setting, including reconstructions of interactions and short excerpts from discussions (Morse & Field, 1996). Rossman and Rallis (1998) stated that "field notes have two major components: the descriptive data of what is observed and the comments on those data or on the project itself" (p. 137). Taking field notes is essential to observation and later analysis, because, "field notes contain descriptions of what has been observed" (Patton, 2002, p. 302). Additionally, this method

provides contextual and behavioural information, enables the researcher to view the situation objectively and assists in the validation and interpretation of information provided by participants (Morse & Field). Morse and Field highlighted that "detailed, accurate and extensive field notes are necessary for a successful qualitative study" (p. 91). The format for recording field notes for interviews in the current research was adapted from Morse and Field (p. 94).

5.5.5 Analysis

Taylor and Bogdan (1998) argued that there is no simple formula for analysing qualitative data. The consensus in the qualitative literature is that data analysis best occurs simultaneously with data gathering as an ongoing iterative process (Huberman & Miles, 1998; Silverman, 2000; Taylor & Bogdan). Taylor and Bogdan describe qualitative data analysis as "a process of inductive reasoning, thinking and theorising" (p. 140). It involves intuition where the researcher usually codes and analyses his/her own data drawing on first-hand experience and knowledge of the setting. Creswell (1998) asserted that data analysis helps guide the research process, including further formulation of research methodology. A suggested formula for data analysis is to read through the data (e.g., field notes, interview transcripts, reports) to get to know the data inside out; record any important ideas as you go (e.g., memo notes, record interpretations); look for emerging themes or patterns in the data; code themes, construct categories; develop concepts and theoretical propositions (Creswell).

In qualitative studies a range of techniques are used to generate meaning from interview data (Kvale, 1996). This research drew on thematic and content analysis

methods. Thematic analysis "involves the search for and identification of common threads that extend throughout an entire interview or set of interviews" (Morse and Field, 1996, p. 114). Themes are usually abstract concepts indicated by the data rather than spelled out explicitly by the interviewee (Morse & Field). Content or question analysis involves grouping the data from each interview into topics or questions and analysing the data according to each question (Morse & Field; Smith, 1999).

5.6 Feedback and Cultural Validation

5.6.1 Feedback

Feedback and dissemination of research findings is a "key element" in the ethics and practice of Aboriginal research and should be conducted "with the same scientific rigour that is applied to the research process itself" (Hunter, 1992b, p. 6). Feedback assumes the ideal of reciprocity and respect (Smith, 1999). Smith explains that the feedback process encompasses more than providing research information to participants, it includes processes for ensuring the validity and cultural appropriateness of research aims, methods, and outcomes and thus increases the accountability of researchers.

A survey of Hunter's (1992b) feedback procedures used in research in Kimberley Aboriginal communities and towns revealed the most effective and informative feedback was provided through direct discussion with local people (e.g., health workers, community people) both throughout the study and soon after completion. Processes and methods for feedback were factored into the study design at the outset.

The feedback process aimed to facilitate community planning to address community problems (Brown, Hunter & Whiteside, 2002). The AIATSIS (2000) recommend that when planning a project, researchers allow time for ongoing review, feedback and discussion; recognise the range of educational backgrounds and experience of participants in order to disseminate information in an accessible form; feed back and discuss results with those involved prior to publication; make all research reports and publications available to the community and participants and provide local, State and National bodies with results if required.

Kvale (1996) explained that a step in the analysis process includes giving participants the opportunity to comment on the interpretations made by the researcher and elaborate on their original statements. Following this, participants begin to act from new insights gained during the interview. As Taylor and Bogdan (1998) pointed out, allowing participants to read and comment on results and publication drafts strengthens the researcher's relationship with participants and builds trust. Furthermore, this process increases Indigenous ownership and control of the research and research information (Smith, 2005).

5.6.2 Validity and Reliability

In qualitative inquiry validity is synonymous with truth (Silverman, 2000). Bishop (2005) explained that in Indigenous research the methodological approach is such that the research is located in the cultural context of the community. The individuals and community decide what is acceptable and unacceptable research and research information. The process is defined by the community, enhancing the validity of the study (Bishop). The methods of triangulation and participant validation also ensure

validity in a qualitative approach (Silverman). Triangulation refers to the use of multiple methods, investigators and corroborating evidence from several sources to provide a rich and authentic understanding of themes and perspectives, as well as strengthening the robustness of the study (Creswell, 1998; Rossman & Rallis, 1998).

5.7 Summary

At the time of the current research there was a dearth of information on how best to carry out community-based intervention research with remote Aboriginal people and communities (Vicary & Andrews, 2001). The approach and methods in the current research were drawn from qualitative inquiry, participatory action approaches, Community Psychology, Indigenous research and the available ethics guidelines for research with Indigenous peoples and communities. The overall approach was multidisciplinary and multi-method (Browne et al., 2005). The methodology grounded the research in context and enabled community engagement and capacity building. The approach was flexible and collaborative allowing the goals and methods of research to be modified and developed in partnership and from the perspectives of the local Aboriginal and non-Aboriginal people and communities involved in this research.

CHAPTER SIX

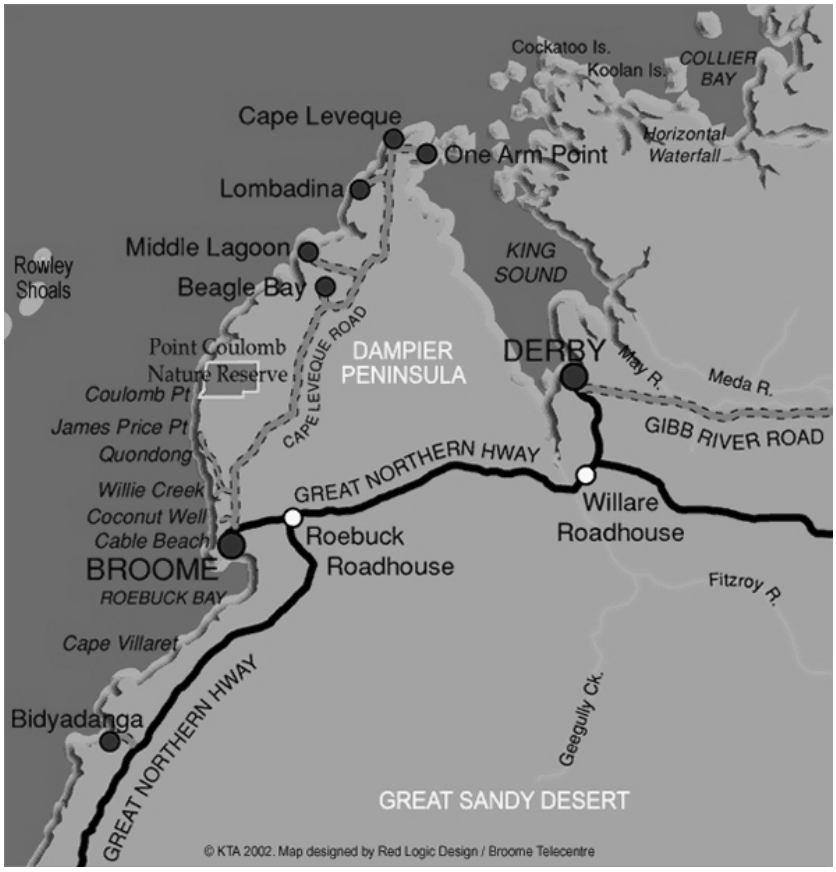
METHODOLOGY

The current research is discussed in three main phases: (1) *Consultation to Collaboration* – formative preparation, agency and community consultation, forming a network of project advisors and support; (2) *Community Engagement in Interviews and Discussion Groups* – participant demographics, development of the interview schedules, data collection and analysis; and (3) *Towards Community Action* – feedback and cultural validation of the research findings and methods. The methodology begins with a description of the research context and the processes for seeking ethics approval and informed consent.

6.1 The Research Context

The following information was collated during the initial phase of the research in 2002 to build a contextual understanding of the research sites. Due to the changing nature of remote areas, particularly Aboriginal communities, the information may not reflect the current situation.

Figure 1. *Map of the Dampier Peninsula West Kimberley*



Source: Dampier Peninsula Map (n.d.). Retrieved June 26, 2008, from http://www.derbytourism.com.au/pages.asp?code=31

6.1.1 Broome

Broome is located in the Kimberley region of Western Australia (WA). The Kimberley is a vast and remote landmass, covering 421,000 square kilometres, larger than the State of Victoria. Broome, the largest of six main towns in the region is located in the south-west of the Kimberley, 2372 km north of Perth. The population of Broome is approximately 11,000 however the town swells to over 40,000 people in the tourist season. The proportion of Aboriginal to non-Aboriginal residents in Broome is roughly half, whereas outlying communities constitute up to 98% Aboriginal people (Australian Bureau of Statistics, 2001). The Indigenous people of Broome and its surrounding area, particularly the Dampier Peninsula, are a mix of

Indigenous, Asian, Arabic and Western heritage due in part to the influx of people involved in the pearling industry in the late 1800s. Broome is surrounded by several remote Aboriginal communities and outstations. The largest Aboriginal communities in this area are Bidyadanga to the south of Broome, and Beagle Bay, Djarindjin, Lombadina and Ardyaloon north of Broome. Community populations range from small family groups to over 700 people (Kimberley Aboriginal Medical Services Council [KAMSC], 2004).

Broome and the surrounding area are popular with tourists and renowned for their Aboriginal cultures and unique landscape where the red pindan soil meets the sandy white shores of the Indian Ocean. Broome has an existence and experience all of its own, known to locals as "Broome-time". The climate is characterised by two main seasons. The dry season (May to October) brings clear skies and little rain for nine months. The wet season (November to April) varies in intensity, but can include cyclones and flooding, which may sever communication and road access, leaving some communities isolated for several weeks at a time.

Health and allied services in the Kimberley are delivered through KAMSC based in Broome and the WA Department of Health. KAMSC is a "health resource body for a group of independent Aboriginal Community Controlled Health Services (ACCHSs) located in the Kimberley region". KAMSC operations are overseen by a Regional Council consisting of members representing the ACCHSs across the Kimberley (Kimberley Aboriginal Medical Services Council, n.d.). KAMSC services include the Regional Centre for Social and Emotional Wellbeing, which has initiated and overseen several mental health research projects and mental health promotion

initiatives, as well as contributing to the training of Aboriginal Health Workers (AHWs) across the Kimberley. The core business of the Regional Centre for Social and Emotional Wellbeing is to train and support AHWs, provide resources and information related to social and emotional wellbeing issues and support to local groups tackling social and emotional problems in the Kimberley. Due to demand in the area and lack of resources, KAMSC social and emotional wellbeing staff may also be involved in counselling Aboriginal people (K. Hamaguchi, personal communication, August 17, 2004).

6.1.2 Ardyaloon Community, One Arm Point

The main remote Aboriginal community involved in this research was Ardyaloon. Ardyaloon is located at One Arm Point on the northern end of the Dampier Peninsula, 221 km via the unsealed, bumpy Cape Leveque road from Broome. The community's population is about 450, (approximately 97% Aboriginal) with over half of the residents under 25 years and 5% over 65 years. Ardyaloon is divided into four main sections, housing the main family groups with amenities in the centre of the community. Some families live permanently on their own outstation communities and others frequent their "blocks" regularly for cultural and recreational purposes.

One Arm Point and surrounding areas of land and sea, including Sunday Island (former mission settlement), are the traditional lands of the Bardi and Djawi people, recognised formally by Native Title in 2005. The community is predominantly Bardi, a discrete cultural and language group. Community members are all related either biologically or through marriage. As a result of dislocation and relocation related to past mission settlement and marriage with people outside One Arm Point, the people

of Ardyaloon also have family connections across neighbouring communities such as Beagle Bay, Lombadina, Djarindjin and the town-sites of Broome and Derby. Therefore, the community population can be transient, especially during holiday periods.

Compared to other communities in the area, culture is still strong for the Bardi people despite mission and contemporary Western influences. “Law business” or initiation of young male youth is practised annually by Elders over the wet season. Elders hold knowledge of traditional stories, dances, ceremonies and ceremonial sites, hunting and fishing practices, as well as tribal geographical boundaries related traditionally to land ownership, marriage, hunting and trade systems. Some Elders in the area have retained knowledge and the practice of bush medicines, traditional healing and craft (e.g., making hairbelts). Cultural knowledge is passed on by some families to younger generations who continue to practise some aspects of Bardi culture, particularly ceremonial dances and singing. Many young males are skilled at making spears and hunting for dugong, turtle (*goorlil*) whilst navigating the treacherous tides in King Sound.

Many Elders speak Bardi language fluently. Bardi is taught in some families and at the local school by Bardi Elders. Middle to young generations speak Bardi to varying degrees, most understand common words and a few speak some Bardi (Aklif, 1999). English and Kriol (Aboriginal English) are spoken by the majority of people in the community. According to Bowern (2002), Bardi language is one of the “healthier” Aboriginal languages in the area, however due to the declining number of speakers,

the language is considered to be endangered and there have been significant attempts to preserve it.

For the Bardi people, particularly the older people, Aboriginal spirituality coexists with Western Christian religions due to missionary influences in the area. On the whole, cultural values are interspersed with a contemporary Western value system to form a continually evolving community identity and way of life. The day to day running of the community is overseen by the Council consisting of eight community people (Elders and mid-generation) elected by the community with representatives from each of the family groups. Council elections occur in October. The Council is headed by the Chairperson and supported by the Aboriginal and Torres Strait Islander Commission (ATSIC) (now its successor the Indigenous Coordinating Centre) based in Broome. The administration of the community is assisted by the Chief Executive Officer (CEO) employed by Ardyaloon Inc. The community had a constant Chairperson, whereas the CEO changed three times during this research. The middle generation, articulate and forthright are often at the forefront of negotiations with outsiders, including government, although community decision making is still one of consensus with consultation and agreement by Elders of primary importance.

Facilities and infrastructure at One Arm Point include a shop, office, mechanical workshop, health clinic, childcare centre, aquaculture hatchery, school (kindergarten to year 11), hall, dilapidated football oval and basketball courts, women's centre (under renovation), Broadcasting for Remote Aboriginal Communities Scheme (BRACS) communication equipment (unused), an airstrip for light planes, family

bough sheds and an undercroft at Middle Beach, a small church and cemetery. Community members are employed through the Community Development Employment Projects (CDEP) to work for community services such as gardening, maintenance, warden/policing, rubbish collection, childcare, shop, administration and aquaculture. Some residents are self-employed tour operators, usually family run. Most community people rely on government welfare and CDEP payments for income. Housing is supplied by the community, administered by Council, funded by ATSIC (now the Indigenous Coordinating Centre). The quality of housing at One Arm Point varies significantly, from condemned dwellings to newly built houses constructed by outside tradesman. There is a shortage of housing and little accommodation for visiting workers.

The community relies on an outside skilled labour force. The One Arm Point School, run by the WA Education Department employs five local staff as Education Assistants and Aboriginal Education Liaison Officers (AELOs), however teaching staff are mainly from outside the community and stay 2 to 3 years on average. The clinic (Remote Area Health Service) is run by the WA Department of Health and employs one local Aboriginal Health Worker (in training) and a Remote Area Nurse on 24-hr call. Nurses stay for short periods, usually 6 months to 2 years. Additional services and programs are provided by visiting staff from agencies and groups based in Broome, Derby and metropolitan Perth. Mental health services, such as a mental health nurse and Aboriginal Mental Health Workers (AMHWs) from Broome Northwest Mental Health Service (NWMHS) are provided to all Dampier Peninsula communities every 4 to 6 weeks, during a 2 to 3 day trip from Broome. A psychiatrist visits once every four months. A paediatrician services the community

along with the Royal Flying Doctor Service on a two monthly basis and a gynaecologist/obstetrician visits every month. In terms of health, the community is considered better serviced than remote desert communities in the Kimberley, however still under-resourced.

Locally run groups and programs impacting on mental health and wellbeing are scarce. The women's group had not been operational for some time and funds for a coordinator unallocated. The youth recreation officer position (funded by the Department for Community Development [DCD]) had not been filled for 2 years. Ardyaloon had received funding from the National Youth Suicide Prevention Strategy to run community initiatives, however the funds remained unspent and at the time the current research took place no-one was coordinating community programs for young people and families. Ardyaloon had some experience with research and outside researchers, particularly linguists and anthropologists, due to their several language research projects carried out with Elders in the community since the 1970s, as well as some participation in mental health research (e.g., *The Gordon Inquiry*, Gordon et al., 2002 and the Western Australian Aboriginal Child Health Survey [WAACHS] Zubrick et al., 2005).

6.2 Ethics and Levels of Consent

Ethics approval to carry out this research was obtained across several levels. Firstly, approval was granted by the Curtin University of Technology Human Research Ethics Committee in April 2002.

6.2.1 Aboriginal Controlled Organisations

The National Health and Medical Research Council (NHMRC: 2003) states that where Aboriginal institutional structures and processes exist these should be utilised by researchers both in community engagement and in seeking ethics approval. The original research proposal was sent to the Western Australian Aboriginal Health Information and Ethics Committee (WAAHIEC) in 2001. Approval from WAAHIEC was contingent on carrying out extensive consultation with key Aboriginal stakeholders, specifically seeking endorsement and approval from KAMSC. Consultations with KAMSC began in late 2001. Discussions were held with the KAMSC CEO and staff at the Regional Centre for Social and Emotional Wellbeing. A written "plain language" proposal requested by KAMSC was sent to KAMSC executive and Regional Centre for Social and Emotional Wellbeing staff and the Chairperson of the KAMSC Regional Council. This proposal was tabled by the Coordinator of the Regional Centre for Social and Emotional Wellbeing at KAMSC Regional Council meeting in November 2002. The proposal detailed background information and the rationale for the research, the research funding source, aims, methods, practical benefits to communities and benefits of research in general, future directions, and a one page summary of the proposal.

KAMSC requested a reply to several comments. Thus more detailed information was provided, namely, how to minimise duplication of previous research; processes for community engagement and consent; protocols for dealing with "at risk" children and youth and disclosures (e.g., of sexual abuse); providing Aboriginal people opportunities to be involved in conducting research interviews; selection of participating communities; the role of KAMSC and other community controlled

organisations; and what the mental health promotion interventions may include. KAMSC then sent a letter endorsing the project, contingent on the development of a memorandum of understanding (MOU) between KAMSC and the Curtin University Project Team.

Following more extensive consultation with KAMSC, further information was supplied to WAAHIEC in December 2002, for their consideration. WAAHIEC granted ethics approval in early February 2003 on the proviso that the MOU be developed with KAMSC. As part of ongoing feedback to WAAHIEC and KAMSC, progress reports (similar to those sent to the funding bodies Healthway and Rotary) were sent to these organisations every six months for the duration of the research.

The MOU was jointly devised through several discussions with KAMSC Regional Centre for Social and Emotional Wellbeing staff and the Project Coordinator (author). Discussions took place from March to August and the final version of the MOU was signed by the CEO of KAMSC and the Director of Research and Development at Curtin University of Technology in early November 2003. The MOU stipulated the roles and responsibilities of the Curtin University Project Team and KAMSC. It covered general ethical issues and those specifically related to research with Aboriginal people and communities (e.g., Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2000; NHMRC, 2001, 2003). The MOU outlined areas including: practical benefits to the community(s) involved; consultation procedures; informed consent; confidentiality and anonymity; access to participant information; feedback of results; and appropriate acknowledgement of local involvement in presentations and publications. A protocol

for identifying and managing distress and participants deemed at risk was also included (see Appendix A for MOU).

6.2.2 Ardyaloon Community Council

Several meetings took place with Ardyaloon Council to formulate the research aims, methods and seek written approval to carry out this project with the community. Council members also directed the Project Coordinator and Project Consultant on additional procedures in order to gain community consent, such as further consultation with nominated Elders and representatives from each of the main family groups. Council members and other community people had considerable time to discuss the project with the researchers and amongst themselves prior to giving their consent for their community to be involved in the research. Council, on behalf of Ardyaloon Community granted written ethical approval in early August 2003, prior to the first study (see Appendix B for statement of community consent). Ongoing approval for community involvement was sought at the main junctures of the research, such as at the start of each of the main rounds of interviews and discussion groups.

6.2.3 Individual Consent

Individual verbal and written consent was obtained from each participant prior to their involvement in interviews and or discussion groups. Participants were given a participant information sheet describing the aims, objectives and data collection procedures, any potential risks, benefits and the right to withdraw from the study at any time (see Appendix C for information sheet). Participants were also given a participant consent form to sign (see Appendix D for consent form). Forms were

discussed and approved by local Aboriginal people (e.g., Project Advisory Group members). For participants with low levels of literacy or English as a second or third language, the information sheet and consent form were read aloud and discussed in detail. In relation to children and youth under the age of 18 years, the information sheet and consent form were given to their parents or carers and discussed in detail. A "youth version" of the information sheet and consent form was also given to children and youth below 18 years. Participants or their parents and carers had time to consult Council, Elders or family members about the project before they agreed to be involved. All participants had full understanding of the nature and procedures of the research, as well as their rights to confidentiality, voluntary participation, and the right to withdraw from the research at any time, prior to agreeing to participate. Written approval was also sought from community members for the use of any photographs taken during the project.

6.3 Phase One: Consultation to Collaboration

In early 2002, the author relocated from Perth to Broome to carry out this doctoral research in the role as Project Coordinator. A non-Indigenous Broome local was employed as the Project Consultant to assist on an ongoing part-time basis. The Project Consultant's initial role was to facilitate introductions to agency service providers and consultations with Aboriginal communities. This process was expedited due to her long established local networks from working as a clinical psychologist in the West Kimberley. The Project Consultant also provided mentoring, supervision and support to the Project Coordinator throughout the

research. The Broome-based project team was supported by the Perth contingent of the project team (e.g., PhD supervisors) based at Curtin University of Technology.

The first phase of the research involved broad consultation with key agencies and groups in Perth and the West Kimberley, as well as preliminary discussions with several remote Aboriginal communities. The aims of initial consultation were to seek local support and endorsement of the research, including building working partnerships with key stakeholders and identifying agencies and communities willing to be involved in the research. It was envisaged that through these relationships, local participation and subsequent ownership and direction of the project would be encouraged. Additional aims included gaining a contextual understanding of local cultural, social, political, historical, and other issues impacting on the mental health and wellbeing of remote young Aboriginal people and communities. This included scoping the types of services, programs and research projects operating in the region and their success or failure in addressing problems impacting on young Aboriginal people.

6.3.1 Agency Consultation

Consultations with agency service providers spanned the Kimberley from Broome to Fitzroy Crossing, although were predominately in Broome. Discussion about the research and related issues occurred during pre-arranged meetings and impromptu talks. Further discussion, observation and experiential learning occurred through immersion in the Broome community, via casual work as a psychologist, volunteer agency committee member (at Burdekin Youth In Action [Burdekin]), attending community forums, conferences, cultural awareness workshops and Aboriginal youth

camps. This provided excellent opportunities for networking and building knowledge and skills related to working with local Aboriginal individuals, groups and communities.

A diverse range of agencies and groups involved in the provision of health, mental health, community, social, justice and educational services to West Kimberley town and community-based Aboriginal people were involved in consultations about the research (see Appendix E for a list of agencies involved in consultation).

6.3.2 Remote Community Consultation

During consultation with agency representatives and other town-based Aboriginal people (some originally from remote communities), several remote Aboriginal communities outlying Broome were nominated for inclusion in consultation about the project. These included Bidyadanga, Djarindjin, Lombadina, Beagle Bay and Ardyaloon. Agency representatives also recommended key people to consult with, usually families with whom they were more closely connected. These networks were utilised, although direction was also taken from the communities as to appropriate methods for consultation to ensure inclusiveness of a range of networks. Agency representatives also gave recommendations on the approach to community consultation in order to facilitate trust in the researchers and research. For example, emphasising transparency of what the project intended to achieve and how, how long the funding was available for and what it could be used for. The accepted protocols and procedures for visiting remote communities were developed initially in consultation with the Project Consultant and other project advisors then adapted

according to the expectations of individual communities and experience in the field, in a continually evolving fashion (Crawford, Dudgeon, Garvey & Picket, 2000).

6.3.2.1 Protocol and Procedures for Remote Community Visits

Communities were notified of potential visits verbally and in writing (Donovan & Spark, 1997; Wettinger & Westerman, 1998b). A fax was sent to the community office (Attention: Chairperson) and other relevant groups (e.g., school, clinic) outlining the dates, purpose and people attending. Visits were confirmed by phone a few days prior and any relevant local information was relayed by the community reference people to the Project Coordinator or Project Consultant (e.g., funerals, ceremonial business, road conditions). Visits to communities were planned with respect to cultural events. For example, outsiders usually do not visit communities during Law time unless invited. Certain events meant people left the community for short periods, such as attending the Shinju Festival in Broome or over the school holidays, thus these times were usually avoided. Certain times of the year, such as the wet season (November to April) made visits to communities, particularly Ardyaloon at One Arm Point, impracticable as roads were cut off due to flooding. While relationships with the community were still being established, periods of instability due to fighting, accidents, and deaths, if known in advance, were usually avoided to allow the community to deal with their crises without the intrusion and pressure of having to consult with outsiders. As relationships deepened over time, the researchers and project were viewed less as outsiders and it was more acceptable to participate in the daily life of the community regardless of what was happening.

On arrival at the community, the project workers attended the office to notify of their arrival, catch up on what had been happening in the community, talk with the Chairperson and or the CEO and meet formally with Council if required. Several meetings (e.g., with school) were usually planned prior to the visit. Meetings with community people were planned prior to visits or evolved during the visit (i.e., not necessarily at a specified time and place, although people expected you would catch up with them if this had been mentioned prior). However, unplanned meetings and discussions were common and occurred at places frequented by community people, such as the shop, near the office, hall, or at Middle Beach. The author and Project Consultant would also visit people's homes however this occurred when relationships were established or upon invitation (Crawford, 1989).

The objectives of each visit to communities were strongly guided by the outcome of previous visits and discussions with community reference people. "Planning meetings" involving the author, Project Consultant, and or project assistants and Project Advisory Group members also took place to determine goals for community visits. Agendas for each visit were written up and given to the Project Consultant and project assistants prior to visits to outline broad objectives of the visit, any planned meetings, preparations or items required from Broome. These agendas also aided the field workers in preparing field reports.

6.3.2.2 Formative Work with Remote Communities

Several 3 to 4 day visits to communities occurred from October 2002 to June 2003. The aims of initial consultation with communities were similar to those for agency consultation (see above). Stakeholders consulted included the Administrator/CEO,

Chairperson and or Council members, Elders, Aboriginal service providers (e.g., wardens, AHWs, AELOs, youth workers/recreation officers), and non-Aboriginal service providers (e.g., school and clinic staff, shop manager). Community women's group members and other interested parents, carers and young people were also involved in discussions about the project. Information was disseminated in written and verbal form. Formal meetings with community councils did not occur until early 2003 due to council elections and subsequent change-over of council members. Meetings with community councils were held in Lombadina/Djarindjin, Ardyaloon and Bidyadanga.

By early 2003 the people of Ardyaloon Community had expressed interest for their continued involvement in the project. Therefore, several 3 to 4 day visits to One Arm Point occurred from January to July 2003 to begin more intensive and targeted consultation. On invitation, the research proposal was discussed in detail with Ardyaloon Council in March 2003. Council members were given a brief written proposal. The proposal was also discussed with One Arm Point school and clinic staff. The proposal clarified the potential roles and responsibilities of Council and community people (e.g., seeking Council approval, consulting with reference people, participation in interviews and discussion groups) and outlined the research feedback processes. A short flyer was given to community people during discussions about the project.

The time spent in the community enabled the establishment of trusting relationships with community people. Spending time yarning with Elders and other community people, participating in cultural activities such as trips to Sunday Island and

outstations, provided opportunities for learning the culture and history of the Bardi and Djawi people. Moreover, through participation and observation of community life, the enormity and complexity of issues impacting on the mental health and wellbeing of young people, their families and communities became apparent. Building and maintaining trusting relationships with agency and community people was a continuing and evolving part of the research process.

6.3.3 The Project Network: Collaboration and Support

One of the outcomes of initial consultation was the establishment of working relationships with local agency and community representatives in order to work in partnership, encourage local direction and ownership of the project and build capacity in agencies and communities. Several agencies based in Broome and Aboriginal people in Ardyaloon Community expressed their desire to be a part of guiding and directing the project. It was identified that several levels of support and a range of expertise were required to carry out this research and adequately represent the views, interests and roles of key stakeholders from Broome and its surrounding Aboriginal communities. Collaborative work on this project required the inclusion of a diverse range of individuals and groups, and flexibility in order to accommodate the existing relationships between agencies, communities and family groups, some of which were characterised by tension and subsequent divisiveness. Therefore, a network of collaboration and engagement was operationalised. Collaboration and engagement across this network took the form of ongoing group, individual, formal and informal discussions as required. Research information was conveyed verbally or in written form depending on the expectations of the audience.

6.3.3.1 Project Advisors

Two Broome-based agencies, KAMSC and NWMHS were identified early on for their key role in health and mental health service delivery to Aboriginal people in the Kimberley region. Both agencies have longstanding networks in the Kimberley and extensive knowledge about working in culturally sensitive ways with Aboriginal communities. The Manager of NWMHS and the Coordinator of the Regional Centre for Social and Emotional Wellbeing of KAMSC put themselves forward for project consultation. Their role was to assist with assessing the cultural sensitivity and relevance of project aims, methods, including protocols for engaging Aboriginal people and communities. They also assisted by providing recommendations for employing project assistants, recruiting participants and consulting key stakeholders involved in the research. Meetings with these project advisors began in February 2003 and continued throughout the research. NWMHS was met separately to KAMSC. KAMSC meetings sometimes involved the author and members of the Regional Centre for Social and Emotional Wellbeing team (e.g., Coordinator, KAMSC Mental Health Professional, Aboriginal Social and Emotional Wellbeing Workers).

6.3.3.2 Project Advisory Group

From the consultation a group of Aboriginal people from key agencies based in Broome expressed their interest or were nominated to form an Aboriginal Project Advisory Group. These service providers or “grass roots” workers were identified for their strong experience and or family connections with remote Aboriginal communities in the West Kimberley, particularly their cultural knowledge and familiarity with youth issues. Permission for service providers to be involved in the

Project Advisory Group was sought from their respective agency. A letter was sent to agency managers to request staff involvement, explain the project, the role and responsibilities of the Project Advisory Group member and to seek endorsement and support for the research. All agencies agreed to involvement of their staff in the Project Advisory Group and hence endorsed the project.

The Project Advisory Group consisted of the Project Coordinator, Project Consultant and initially seven Aboriginal representatives from ATSIC, Kimberley Community Drug Service Team (KCDST), Garnduwa Amboorny Wirnan Kimberley Sport and Recreation (Garnduwa), Burdekin, Broome Regional Aboriginal Medical Service (BRAMS), and Department of Corrective Services (DoCS). The composition of the group changed when service providers changed jobs or left Broome. Although numbers remained around seven, there were five consistent Aboriginal Project Advisory Group members throughout the project. These members were three females and two males, ranging in age from 22 to 44 years. These Project Advisory Group members were affiliated with key agencies and several Aboriginal communities (i.e., Bidyadanga, Beagle Bay, Djarindjin, Lombadina and Ardyaloon) involved in the research.

Project Advisory Group meetings were held in Broome at Broome Community (CIRCLE) House, a place deemed neutral by Project Advisory Group members. Meetings began in January 2003 and were held, on average, every 2 months until the end of 2004. Project Advisory Group members were also involved in informal discussions throughout the project, pilot interviews and interviews for the main studies. The overall role of Project Advisory Group members was to guide the

research. This meant ensuring the aims, methods and outcomes were culturally sensitive and relevant to Aboriginal people living in Broome and surrounding remote Aboriginal communities.

The Project Advisory Group provided direction on community consultation procedures; selection of research sites; recruiting participants and Aboriginal project assistants; development of interview questions; data collection and feedback methods; and validation of research findings. Working with the Project Advisory Group was characterised by knowledge exchange, whereby Project Advisory Group members imparted local knowledge and expertise to the researchers, and the Broome Project Team further developed the skills and knowledge of local service providers, particularly in the area of research, mental health promotion and community development. Some Project Advisory Group members were also involved in visits to communities which facilitated cross-agency/community/project collaboration. Project Advisory Group members were pivotal in facilitating relationships and engagement of agency and community people by "vouching" for the researchers and the project.

6.3.3.3 Community Reference People

Key people from Ardyaloon Community were recommended by the Project Advisory Group and identified during initial visits to One Arm Point. Several were identified as community reference people who were also endorsed by Council and the main family groups. Several reference people, including the Chairperson, Elders and members of each family group, provided information to the author and Project Consultant about how best to carry out the research with the people of Ardyaloon

Community. The researchers discussed the proposed aims and methods of the research on an ongoing basis with reference people to seek their guidance and validation. Reference people provided cultural and other local information to facilitate sensitive cross-cultural research practices. This was consistent with other research conducted in the Kimberley (e.g., Vicary, 2002).

For example, community reference people relayed information to the Broome Project Team about suitable dates and times to visit the community, relevant events occurring in the community (e.g., cross-agency meetings, cultural activities) for the researchers to participate in, and practical advice (e.g., poor road conditions). This information enabled the author to plan community visits according to local priorities and agendas. Community reference people such as council members were involved in more formal discussions about the project, usually during council meetings. Other reference people were consulted individually or in small family or gender specific groups (e.g., the “old girls” group).

6.3.3.4 Project Assistants

Several project assistants were employed throughout the research. Aboriginal people based in Broome and Ardyaloon were recommended by project advisors, the Project Advisory Group and community reference people. Additional project assistants, both Aboriginal and non-Aboriginal, were recruited through job advertisements in the local paper. Project assistants were employed by Curtin University of Technology on casual contracts. They were trained and managed by the Project Coordinator from Broome.

Project assistants fulfilled a variety of roles including assisting with community consultation and field trips, data collection and transcribing interviews. All project assistants signed confidentiality agreements related to privacy of information pertaining to individuals and families involved in the research (see Appendix F for project assistant confidentiality agreement). Overall, 5 Aboriginal and 5 non-Aboriginal project assistants were employed. Project assistants were given considerable support and frequent meetings were held with project assistants to seek an update on their progress and discuss any issues arising.

In 2004, a Senior Aboriginal Project Assistant was employed and trained in writing field notes and reports, engaging young people, identifying and dealing with at risk young people, basic counselling skills, transcribing interviews and so on. Training local project assistants was based on the same premise as collaborative work with the Project Advisory Group and other advisors, which emphasised information exchange, including building the researchers' knowledge and skills in culturally sensitive practice with communities and up skilling project assistants in mental health research and project delivery.

In summary, the methods employed to establish and maintain varying levels of consent and collaboration enabled the research to reflect the worldview and priorities of agencies and communities, particularly the people of Ardyaloon Community. These processes aided in building local capacity and conducting sensitive cross-cultural work, as well as facilitating accountability of the project team and building lasting relationships with local people.

6.4 Phase Two: Community Engagement in Interviews and Discussion Groups

6.4.1 Aims

A key objective of Phase One was to collaboratively formulate the research aims and methods for data collection. The broad research questions (e.g., what are the mental health and social and emotional problems impacting on young people in remote Aboriginal communities and what do local people want to see happen to deal with these problems?) were discussed at length during consultation. Themes that arose from consultation and influenced the formulation of aims included: defining problems holistically and locally, including local definitions of youth wellbeing and resilience; high need for intervention as opposed to purely descriptive research; and focus on resilience/strengths rather than just deficits. Therefore, the research aims were as follows:

(1) To identify and describe the mental health and social and emotional problems affecting Aboriginal children and youth living in remote communities in the West Kimberley.

To seek local people's perceptions of:

- Major mental health and social and emotional problems affecting young people
- Signs and symptoms
- Coping strategies

- Risk and protective factors
- Definitions of youth wellbeing and social and emotional resilience

(2) To identify and describe goals and methods for intervention to promote wellbeing and build resilience in remote young Aboriginal people, families and communities.

(3) Provide feedback and culturally validate the research findings.

6.4.2 Participants

6.4.2.1 Selection of Research Sites

A pool of town-sites and remote Aboriginal communities in the West Kimberley was identified during consultation as suitable for involvement in this project. Several factors were considered in the selection of sites for this research. These inclusion factors were: practical considerations (e.g., budget and resources, infrastructure, proximity to Broome) in terms of being able to carry out and sustain the project over time; involving town-based agencies and remote community-based people; communities with populations over 250; communities with few or no mental health programs, services or research projects; towns and communities put forth by local Aboriginal people during initial consultations, and most influentially, those sites willing to be involved, perceiving the project as relevant and of benefit.

The majority of initial consultations took place in Broome. Broome was selected as the main town-site to be involved in the research due to the agencies' interest generated from initial consultation and willingness to engage in the research.

Therefore, Aboriginal communities near Broome were selected for potential involvement, as opposed to those outlying Derby and Fitzroy Crossing. Visiting towns and communities further a field beyond initial consultation was considered too costly and therefore impracticable in terms of sustaining the project over time. Including fewer sites meant meaningful engagement could take place, and fulfilment of broader project goals to carry out interventions identified in this research. The options for inclusion of remote Aboriginal people were to engage family groups which spanned Broome and communities, or to select discrete communities. To be more inclusive of a range of family groups and to take advantage of the existing infrastructure provided within communities, community sites were selected. Several communities were prioritised in the selection pool.

Some of the reasons for community involvement or lack of involvement at the time of the current research were as follows: Bidyadanga - despite their initial interest and engagement of two local project assistants, Bidyadanga's CEO and Council requested a delay in the community's involvement because the community was over committed with other projects. Beagle Bay - was well supported by KAMSC Regional Centre for Social and Emotional Wellbeing and involved in KAMSC social and emotional wellbeing programs and research. Lombadina/Djarindjin - some youth activities (e.g., recreation officer) were operating well in the community. Ardyaloon - expressed the strongest interest, identified a need for the project and began to engage early on in the research process. The community experienced a high rate of social and emotional problems, lacked working programs and services for young people and families, and was more isolated from agencies in Broome compared to neighbouring communities thus often "missed out" on interventions.

6.4.2.2 Recruitment of Participants

Participants for interviews and discussion groups were selected from the two research sites, Broome (town) and Ardyaloon (remote Aboriginal community). Recruitment of people to be involved in interviews and discussion groups was based on who could best inform the research, for example, service providers working in health, mental health or justice who were also parents of young Aboriginal people. Recruitment also rested on people's desire to engage with the researchers and the project. Therefore, procedures for recruiting participants were based on purposeful sampling rather than random sampling (Patton, 2002; Silverman, 2000). Participants volunteered their involvement during agency and community consultation or were recommended by people in the network of project advisors. In addition, participants were nominated by other participants at the time of their interview, thus "snowballing" of participation resulted (Taylor & Bogdan, 1998). This is also referred to in an Aboriginal context as "vouching", whereby community members expressed interest/participation/ trust in the researchers to other community members who then nominated themselves and others to be involved (Bishop, Vicary, Andrews & Pearson, 2006; Vicary, 2002).

The number of participants required for qualitative studies is relatively small due to the in-depth nature of inquiry (Patton, 2002). Kvale (1996) suggests interviewing enough people to find out what is needed. Due to the differing viewpoints under investigation, a wide range of people were included, such as Elders, parents, carers and young people, as well as representatives from a range of agencies and each of the family groups at One Arm Point. A concerted effort was made to include those people who had relocated to outstations near One Arm Point, and groups known to

be difficult to engage, such as older youth. The number of interviews in qualitative research is usually determined by saturation of information. However, in this project, where engagement in the research process was an overarching aim to facilitate local ownership and hence longer term sustainability of the project, people interested in sharing their insights were not discouraged from participating. Many people who participated in the first round of interviews also engaged in subsequent discussion groups, as well as in the feedback and validation groups.

6.4.3 Demographic Characteristics

A total of 91 people were involved in interviews and discussion groups for Study 1 and 2 of this research. Thirty-two participants lived in Broome and 59 were from Ardyaloon Community and outstations situated near One Arm Point. Table 1 provides a breakdown of participants' involvement in Study 1 and 2.

Table 1. *Participants' Involvement in Study 1 and 2*

Location	Study 1 & 2	Study 1	Study 2	TOTAL
Broome	19	1	12	32
OAP	20	18	21	59
TOTAL	39	19	33	91

Respondents were Aboriginal and non-Aboriginal service providers and Aboriginal Elders, parents, carers and young people. Participants were classified as service providers if they were employed in health, mental health/social and emotional wellbeing, welfare, justice, education or sport and recreational services. Parents and carers were parenting Aboriginal children and youth. Some parents and carers were

also service providers. Participants were said to be youth if they were aged 13 years up to and including 25 years. This cohort consisted of some young people who were also parents and young people who were service providers. It is important to note that Aboriginal people may not identify themselves as youth if they are aged 18 to 25 years, especially if they have gone through Law and/or are parents. However, on consultation with the Project Advisory Group it was discerned that for the purposes of this research young people aged 18 to 25 would be termed youth. Table 2 provides the age, gender and ethnicity of Broome and One Arm Point participants.

Table 2. *Age, Gender and Ethnicity of Participants*

Location	Gender		Age (yrs)		Ethnicity	
	Female	Male	Mean	Range	Aboriginal	Non
Broome	22	10	32.6	18-48	27	5
One Arm Point	28	31	36.6	13-87	54	5
TOTAL	50	41			81	10

The age distribution and type of people (e.g., Elder, youth) interviewed differed somewhat across the research sites. This was due to the relative ease in engaging Elder women and younger youth in Ardyaloon Community compared with Broome, predominantly due to the length of time the researchers stayed in the community building relationships with community people. In Broome more time was spent building relationships and engaging with agency representatives.

As part of the research, participants were asked to identify their level and type of education and training, as well as their employment status and family income level.

All of the Broome participants had completed year 10 and 84% of respondents had completed or were enrolled in tertiary education. Seventy-one percent of participants from Ardyaloon Community had completed year 10 and 32% had completed or were currently undertaking tertiary studies. Tables 3 and 4 present the education level and type of education, training and employment reported by participants.

Table 3. *Education, Training and Employment of Broome Participants*

Education Level	N	%	Education/ Training	N	%	Employment	N	%
Secondary (yr)								
8-9	0	0	Health	11	41	Health	10	32
10	2	6	Community	4	15	Community	10	32
11-12	3	9	Childcare	2	7	Sport/Recreation	4	13
			Education	1	4	Education	2	6
Tertiary (complete)			Admin/Business	5	19	Admin/Business	3	10
			Trade	2	7	Trade	2	6
Diploma	9	28	Arts Degree	2	7			
Bachelor	3	9						
Postgraduate	1	3						
Tertiary (enrolled)								
Diploma	9	28						
Bachelor	4	13						
Postgraduate	1	3						

Note: Percentage totals do not equal 100 due to rounding.

Table 4. *Education, Training and Employment of One Arm Point Participants*

Education Level	N	%	Education/ Training	N	%	Employment	N	%
Secondary (yr)								
8-9	17	29	Health	2	9	Health	2	4
10	10	17	Community	1	4	Community	3	6
11-12	12	21	Childcare	0	0	Sport/Recreation	0	0
			Education	5	22	Education	10	20
Tertiary (complete)			Admin/Business	5	22	Admin/Business	0	0
			Trade	2	9	Trade	0	0
Diploma	12	21	Aquaculture	5	22	Tourism	1	2
Bachelor	3	5	Tourism	3	13	CDEP	22	44
Postgraduate	0	0				Pension	12	24
						N/A	9	-
Tertiary (enrolled)								
Diploma	3	5						
Bachelor	1	2						
Postgraduate	0	0						

Note: Percentage totals do not equal 100 due to rounding.

The income level for respondents was categorised according to annual family income, from less than $20,000; $20,000 to $50,000; to greater than $50,000. Table 5 provides the reported family income of respondents from Broome and One Arm Point.

Table 5. *Family Income of Participants*

Location		Broome		One Arm Point	
		N	%	N	%
Family Income ($)	<20,000	6	19	33	56
	20,00-50,000	17	53	19	32
	>50,000	9	28	7	12
TOTAL		32	100%	59	100%

Another aspect of the demographic information collected from participants centred on language groups and participants' use of Aboriginal languages. Most Aboriginal participants identified their language/skin group. Broome participants represented nine different language groups, including Karrajarri, Yawuru and Nyul Nyul to name some. Eighty-eight percent of the respondents from Ardyaloon Community who identified their language group, identified themselves as Bard/Bardi.

Out of the 16 Broome participants who rated their usage of Aboriginal languages, 19% agreed they spoke their language, 56% spoke some of their language and 25% did not speak or understand their language. Of the 51 Ardyaloon respondents, 37% spoke their language, 57% spoke some of their language and only 6% did not speak the Bardi language. All Aboriginal participants spoke English and many also spoke Kriol (Aboriginal English). For some remote community participants English was their second or third language. See Appendix G for tabular representations of Aboriginal language groups and the number of participants who reported speaking their Aboriginal language.

Research participants were also asked about their family configuration and number of people living in their homes. The constitution of families was categorised into nuclear, blended (e.g., step-family), extended (e.g., immediate family and relatives), sole parent and so on. Most of the Broome and Ardyaloon participants lived in nuclear families, with 19% of Broome participants compared with 40% of Ardyaloon participants living in extended family situations. Most of the Broome respondents lived in households with 1 to 4 residents (64%), whereas most of the Ardyaloon participants had from 5 to 7 people living in one home (52%). Eight percent of community households had occupancy levels from 8 to 9 people compared to no Broome participants having households in excess of 7 people. See Appendix G for tabular representation of participants' family constellation and amount of occupants in the home.

6.4.4 Interview Materials

6.4.4.1 Development of Interview Materials

People involved in consultation expressed a preference for interviews and discussion groups rather than questionnaires or surveys for data collection. The main tool for data collection in this research was the semi-structured interview schedule. The interview questions were developed in collaboration with the network of project advisors, particularly the Project Advisory Group. The development of interview schedules and related forms occurred from January to May 2003, with further revisions until September 2003. Initially, a large pool of questions was devised based on information gathered during consultation and a review of the literature pertaining to Aboriginal mental health and wellbeing. These questions were reduced to 12 main

questions related to the project aims. This method is consistent with that used by Vicary (2002). The preliminary interview schedule and forms were trialed with Project Advisory Group representatives. Revisions of the interview questions (e.g., wording of questions) and schedule (e.g., order of questions) took place prior to interviews in Broome. Following interviews in Broome and further discussion with community reference people, additional modifications were made before data collection with remote community participants. Several revisions of the interview schedules and forms took place to ensure the language and content was sensitive and relevant to both town and community-based Aboriginal people. Huberman and Miles (1998) point out that in contrast to experimental studies, "changes in observational protocols or interview schedules in a field study usually reflect a better understanding of the setting, thereby heightening the internal validity of the study" (p. 186).

6.4.4.2 Semi-structured Interview Schedules

Three interview schedules were used in interviews for Study 1 namely, the parent/carer interview schedule, service provider interview schedule and youth interview schedule. These schedules related to the first research aim which was to identify and explain the mental health and social and emotional problems affecting Aboriginal children and youth living in remote communities in the West Kimberley, including: signs and symptoms; coping strategies; risk and protective factors; and definitions of youth wellbeing and resilience/strengths. The schedules covered the same questions, with slightly different wording to suit the target audience (e.g., town or remote community-based Aboriginal person; parent or young person). The terms of reference used in the interview schedules were vetted by local Aboriginal people

(e.g., Project Advisory Group, community reference people) and thus represented the participating cohort which included participants with English as a second or third language. Questions included:

> *What sort of social and emotional problems (hard times) do young people in this community have to deal with?* (defining problems)
>
> *When a young person is going through a really hard time what things have you seen young people do to try and deal with their problems? (Prompt: what about the family…what do they do to help? What about the community?…Outside agencies?* (coping strategies)
>
> *Some people overcome a lot of problems and get on with their life.*
>
> *What do you think makes young Aboriginal people "strong"?* (resilience)

For discussion groups (Study 2), seven questions were included in the interview schedule. These questions centred on the second research aim. The second aim was to identify and describe goals and methods for intervention to promote wellbeing and build resilience/strengths in remote young Aboriginal people, families and communities. Questions included:

> *What would you like to see happen in your community to help young people and their families deal better with problems?* (intervention goals)
>
> *Who would take part? Why these people?* (intervention methods)

Who would be the best people/agencies to run the activities in the community?

A standard preamble about the purpose, content and process of the interview or discussion group was included at the beginning of each interview schedule. Some questions included a brief lead-in statement to establish the context for the question. Several prompts were also incorporated into the interview schedules to facilitate discussion, for example, about issues impacting at several levels (e.g., individual, family, community, and outside agency influences). The interview schedules concluded with information about follow-up interviews and feedback of interview information, as well as information about what was happening next with the project (see Appendixes H and I for examples of the semi-structured interview schedules used in Study 1 and 2).

6.4.4.3 Demographics Form

The demographics form (see Appendix J) included general demographic information (e.g., age, gender, ethnicity, level of education, employment and income). The form requested information about the participants' language group, whether they spoke their Aboriginal language, the constellation of participants' families and number of people living in their place of residence.

The interview materials were combined into a package which contained an interview protocol, information sheet and consent form, demographics form, interview schedule and the interview observations (notes) form. This form was for interviewers to record observational or thematic information about the setting, interviewee and

interview that was not recorded on audio-tape. The format for this form was adapted from Morse and Field (1996, p. 94). The package also contained the protocol for identifying and dealing with distress or disclosures. For groups, a discussion group protocol and participant list were also included with the other forms.

6.4.5 Procedure

6.4.5.1 Pilot Study

The Project Coordinator and Project Consultant conducted six individual interviews with four Project Advisory Group members in March and April 2003 in order to test the interview procedure, interview schedule and forms. The researchers requested feedback from the pilot participants about the interview procedure and questions, for example the cultural appropriateness and relevance of questions and procedures and how adequately questions addressed the research aims. The pilot interviews were lengthy due to the number of questions covered and the depth of information participants provided. Therefore, in order to maximise the engagement of participants, it was decided to split the interview schedule into two parts and conduct two rounds of interviews

6.4.5.2 Study 1: Problems, Risk and Strengths

Broome

Study 1 interviews were carried out in Broome over a two month period in mid 2003. The interviews were conducted by the author and Project Consultant both of whom had a reasonable to very good rapport with their interviewees. Potential participants were contacted by phone or in person prior to their interview to confirm their

involvement. The information sheet and consent form were given to participants to read and sign before the interview. The interview process was explained to the interviewees and they had the opportunity to have any questions about the interview answered prior to their involvement. Some respondents requested the interview questions to read before their interview. Interviews were conducted at a place deemed suitable by the interviewees, such as their residence, place of employment or at Broome Community (CIRCLE) House. The respondents had the option of having a nominated cultural consultant present to guide the interviewer on any cultural issues that may present. Although all Broome participants declined this, some participants chose to be interviewed in pairs. The demographics form was completed at the time of the interview and the consent form was signed if it had not been done prior. Interviews were an informal "yarn" using the relevant interview schedule (Vicary, 2002). Interviews averaged 1.5 to 2.5 hrs duration; the time was flexible to allow participants to have plenty of time to think about their responses and tell their story. At the conclusion of the interview participants were given an incentive voucher (donated by Chicken Treat) thanking them for their participation. Incentives for town-based participants in the form of vouchers was deemed appropriate by the Project Advisory Group. Overall, 20 Broome participants were involved in 19 interviews as part of Study 1.

Ardyaloon Community, One Arm Point

For the purpose of data collection for Study 1 several 3 to 4 day visits to Ardyaloon Community were made throughout August and September 2003. The interview procedure was similar to that used in Broome with a few adaptations. The author and Project Consultant were the interviewers. The interviewers tended to interview

participants closer to their own age. Interviews were conducted at any of the community amenities (e.g., outside the office, school, clinic, shop house, women's centre), at Middle Beach, participants' houses/verandas and some interviews were held at outstations. Prior permission was obtained for the use of community facilities. Interviews were predominantly conducted individually, except for one group discussion carried out with Elder women, referred to as the "old girls group". Some members of this group preferred to speak in their native language Bardi, therefore, one of the Elders assisted as a cultural consultant and translator to help facilitate the group discussion. A Project Assistant living at One Arm Point was employed to help recruit and transport participants to interviews. Following the interviews, all respondents were given an incentive voucher to the value of $10 to purchase supplies at the Ardyaloon Shop. This incentive was determined by community reference people. Thirty-eight community people were involved in 31 interviews. Broome participants reflected on their experiences working with remote community people and or personal experiences occurring within their families and extended families, many of whom were from remote Aboriginal communities (e.g., One Arm Point, Beagle Bay, Bidyadanga). Respondents from Ardyaloon Community drew directly from their own experiences living at One Arm Point.

6.4.5.3 Study 2: Community Solutions

Broome

Study 2 interviews and discussion groups were held in Broome in October and November 2003. Existing participants were invited to be involved and new participants were also included. New participants were given an information sheet, consent form and demographics form to complete prior to the interview or discussion

group. Interviews and groups were conducted by the author and Project Consultant. A service provider from Garnduwa Sport and Recreation (also a Project Advisory Group member and young person) facilitated a group involving Aboriginal youth because of her existing rapport with this cohort. Discussions for Study 2 involved brainstorming activities for building strengths and promoting the wellbeing of young Aboriginal people and their families living in remote communities, and how best to carry out these activities in the participating community. Most of the interviews were small group discussions. The largest group was the youth group with 5 participants. Thirty-one people were involved in 21 groups for Study 2 in Broome.

Ardyaloon Community, One Arm Point

Study 2 occurred over a two week period in October 2003, in between data collection in Broome. Community participants who had been interviewed in Study 1 and new participants volunteered their involvement. Many interviewees were met prior to the discussion group to confirm their involvement. Discussion groups in One Arm Point were facilitated by the researchers. Additionally, two Youth Workers, one male and one female from the Broome-based agency Burdekin Youth In Action (also Project Advisory Group members and young people) facilitated groups with high-school-aged Aboriginal youth. These groups were held at the One Arm Point School during school hours and were well supported by school staff. The Youth Workers had worked with Bardi young people and thus had good rapport with community youth, and skills in engaging young people in general, particularly those under 18 years. Other participants, such as older male youths were offered alternate interviewers (e.g., older male) as opposed to the author (non-Aboriginal woman, early 30s). However, they were content being interviewed by the author on the condition that the

interview took place out of public view. This seemed to reflect their apprehension/shame about being associated with a mental health project even more so than being interviewed by a *Gardyia* (non-Aboriginal) woman. Some participants preferred to talk with an outsider rather than being interviewed by someone they were more closely connected to due to concerns about confidentiality. Overall, forming groups, selecting interviewers/facilitators and choosing interview locations required flexibility and a range of options to accommodate the preferences of participants, and respect cultural and social practices (e.g., avoidance relationships, separateness of men and women). In One Arm Point, 42 community people participated in a total of 18 groups.

6.4.5.4 Debriefing Participants

Almost everyone involved in this project had been affected in some way, either directly or indirectly, by one or several traumatic events with many facing crisis on a regular basis. A written protocol for identifying and managing participants experiencing distress or deemed at risk of harm to themselves or others (e.g., suicidal ideation, sexual abuse) was developed as part of the MOU in Phase One (see appendix A for MOU which includes the risk protocol). As part of this process, referral options were identified (e.g., with NWMHS, KAMSC, One Arm Point Clinic, Council). Referral procedures were discussed with the targeted agencies. The protocol was discussed with key service providers to clarify the responsibilities of the project team and agencies in assisting individuals and groups in managing distress and disclosures throughout the project.

All participants were offered debriefing as part of the interview process. Due to the informal nature of interviews and discussion groups and the time spent in Broome and One Arm Point during and after the data collection, the interviewers were able to meet with participants and other community people on an ongoing basis to discuss any concerns that arose from interviews or groups. Youth were a particularly vulnerable group and care was taken in interviews when discussing issues impacting on young people, such as suicide, sexual abuse and family fighting. The interviewers, also psychologists were able to assess risk and provide support. This usually involved observation, informal discussion immediately after interviews and follow-up during subsequent visits, as well as discussing any issues with families and community reference people where needed. Due to the lack of resources for dealing with mental ill-health in the community, researchers fed back any issues of concern for visiting mental health and wellbeing services to address. In addition, community members were provided with information on agencies and service providers to contact for information and assistance.

6.4.5.5 Data Management: Transcription and Review

Five casual project assistants (one longstanding) were employed and trained to transcribe interviews and discussion groups. Interviews and discussion groups were audio-taped then transcribed after each round of data collection. Information from interviews and discussion groups were transcribed according to Morse and Field's (1996, p. 107-8) suggested format. This format included transcribing the interview verbatim, including expressions, emotional responses and non-verbal or contextual information (e.g., noises). This enabled the researcher to record in more depth the experience which was communicated by the interviewee. To ensure confidentiality

and anonymity of respondents, names or identifying information were not included in the transcript. A template of how to transcribe the interviews was given to all transcribers to ensure uniformity and reliability in the approach (Kvale, 1996).

All transcripts were reviewed by the author or the Project Consultant, with some transcripts from the feedback and validation study reviewed by the Senior Project Assistant. Reviewing involved listening to the taped interviews and checking the transcript for accuracy of typing and language to account for any nuances in language. Transcripts were stored systematically in files in a secured cabinet and stored electronically using NVivo Qualitative Data Analysis computer software program, version 2.0 (NVivo).

6.4.5.6 Data Coding and Analysis

The primary data source was the transcripts from interviews and discussion groups which reflected the research questions. Information was also obtained from observation and participation in formal and informal discussions with agency and community people, as well as immersion in daily life in Broome and Ardyaloon Community (e.g., trips to Sunday Island). Research information such as contextual issues, emerging ideas and themes, were written up in field reports and field process notes (Bernard, 1988) and served both as secondary data sources and corroboration of information given in interviews and discussion groups. Additional data was collated from the relevant literature, local agency reports, and cultural and historical information.

Iterative data analysis occurred throughout the research process, in that information was collected, analysed and reviewed on an ongoing basis in a process which involved reflection, formulation and reformulation of emerging themes and hypotheses (Bishop, Sonn, Drew & Contos, 2002; Silverman, 2000). The author analysed the data (Taylor & Bogdan, 1998). The main data analysis took place after each stage of interviews and discussion groups. Data analysis involved thoroughly reading all transcripts to get an overall understanding of the information given and coding the transcripts and other information (e.g., field reports) into themes. Additional notes were also made when reading through transcripts to record key themes as they emerged throughout the interview or discussion group. The interview data was interpreted, coded, and analysed according to content (e.g., question-driven) and thematic analysis using NVivo (Cresswell, 1998). This enabled data to be analysed and categorised according to each question, and into themes which emerged directly from the data, in a more generative or "ground up" process (Morse & Field, 1996).

Following the initial data analysis, the core themes and examples of responses to interview questions were collated into a summary document for the purpose of feedback and validation with participants from Broome and Ardyaloon Community, as well as other interested agency representatives. Further analysis of data took place after the completion of the field research in 2005.

6.5 Phase Three: Towards Community Action

6.5.1 Feedback and Validation Procedures

Feedback and validation was an ongoing part of the research process (Hunter, 1992b). There were several procedures put in place for people involved with the research (e.g., Project Advisory Group, community reference people) to receive and comment on information throughout the project. Participating agencies and community people were given mid and end of year progress reports in 2003 and 2004. Progress reports were brief, plain language reports usually written up as flyers. In Broome, progress reports were mailed or given to participants and key stakeholders. In One Arm Point the reports were distributed in all community mailboxes and handed out to others interested in the research. Ongoing feedback meant involvement of local people in continued discussion and reflection about the goals, direction and outcomes, as well as the approach to research. Consistent feedback also contributed to the accountability of the researchers, enhanced trust in research relationships and increased engagement of agency and community people in the project.

6.5.1.1 Study 3: Feedback and Validation of the Research Findings

The main feedback and validation phase took place after Study 2. The purpose of this phase was to ascertain whether the information gathered in interviews and interpreted during the analyses accurately reflected the worldview of participants and was reported in a culturally safe manner. The feedback and validation also aimed to maintain trusting relationships and facilitate engagement of agency and community people in the project. Discussion and reflection on the research findings, particularly

"community solutions" aimed to generate further interest and motivation towards the community carrying out their nominated interventions to build "strong and happy" young people.

At the end of 2003, after the completion of Study 2, a visit to Ardyaloon Community was undertaken to provide initial feedback to the community on information from interviews and discussion groups and to discuss with the community the direction of the project in 2004. Faxes were sent to the Council and school to remind them of intended meetings. Flyers were sent and put up around the community to advertise forthcoming feedback meetings. Community members were given a feedback information sheet and summarised version of the research data. The research information was compiled into a plain language six page report with information listed under main headings corresponding to the research aims/questions. Participants from Study 1 and 2 were targeted for involvement in discussions, although other interested people were also encouraged to participate. Meetings were held with Ardyaloon Council, Elder women, clinic and school staff, and high school participants. Twenty-nine people were involved in 5 groups. Other community people (e.g., youth, parents, carers, Elders) were involved in more informal discussions. The information was left in family mailboxes for those people absent from the community. Feedback discussions were undertaken by the author and Project Consultant with assistance from a male Youth Worker from Broome agency Burdekin who discussed the information with a group of high school boys. The information used in feedback to Ardyaloon, including a project progress report was also discussed with the project advisors (KAMSC, NWMHS) and Project Advisory Group members.

For the purposes of more extensive and in-depth feedback and validation, the main information from Study 1 and 2 was collated into the summary results document. This included key headings: social and emotional problems affecting remote young Aboriginal people; recognising signs and symptoms; unhelpful and positive ways of coping; risk factors which can increase the development of social and emotional/mental health problems; protective factors which can reduce the development of social and emotional/mental health problems; youth resilience/strengths; youth wellbeing; and activities and strategies for promoting remote Aboriginal youth and community wellbeing. The information was presented clearly and plainly in tables under the main headings in order for participants to provide specific comments on each section.

Participants were asked to provide feedback about the validity of the research findings and comment on the overall project and the research process. The schedule of questions used in Study 3 feedback and validation interviews and discussion groups, as well as the mail-out, included the following questions:

> *What do you think of the summary information?*
>
> *Do you think the summary information is consistent with what you said in your interview/discussion group?*
>
> *Do you think the summary information is consistent with what you know about the social and emotional issues for young Aboriginal people and families living in remote communities?*
>
> *Do you have any more relevant information to add?*

Please add any final comments on the project, research process or summary information?

The feedback and validation study aimed to include the network of project advisors, interview respondents from Broome and Ardyaloon and others interested in the research. Firstly, the summary results were discussed with the Project Advisory Group, followed by discussion groups and some individual interviews held from June to September 2004 in Broome and One Arm Point. The summary results were also discussed with KAMSC Regional Council at a meeting in Derby, and sent to WAAHIEC in September 2004. Participants in the actual feedback and validation study were sent or given the summary results and feedback and validation questions prior to meetings to allow time for reading and discussion. Groups were facilitated by the author, Project Consultant or Senior Project Assistant. A protocol for conducting groups and interviews was given to interviewers to ensure uniformity in the feedback procedure. People not directly involved in groups were given the opportunity to comment on the findings via post using the feedback form. Discussion groups began with the facilitator reintroducing herself and the project, explaining the purpose of the discussion, recapping the aims of Study 1 and 2, explaining "validation" and the importance of receiving feedback, and the proposed use of the feedback information (to guide the development of activities in One Arm Point and other remote Aboriginal communities). Participants were also given a brief progress report (December - June 2004) which summarised the recent events of the project. Discussion group times ranged from 1 to 2.5 hrs. In Broome, 12 groups were held to discuss the summary results. Fifty-eight people from 20 agencies and groups across the Kimberley, mainly Broome took part.

The second phase of feedback for Ardyaloon Community, involved sending the summary results to the 59 participants, plus all other families in One Arm Point, with a request for feedback either by mail or in community-based discussion groups. A total of 8 groups were held with 43 community people. Half the people from Ardyaloon involved in Study 1 and or 2 took part in these feedback discussions. Groups consisted of youth, parents, Elders, council members, school students and staff, clinic staff. Feedback discussions took place over seven, 4 day visits to One Arm Point from July through September 2004, beginning with feedback to Ardyaloon Council. A larger number of young people were involved in the feedback groups than the first two studies, due to more time spent building rapport with young people by the time the feedback study took place.

A total of 101 people were involved in the feedback and validation study. Thirty seven of these participants had been involved in the first two studies. Participants also had the opportunity to provide written feedback at the time of their interview. Thirteen Broome participants and 6 community participants completed feedback forms. An additional 27 Broome agency representatives (not involved in discussion groups) received the summary results, feedback questions and a progress report by post or email. Five responded by providing written feedback. Individual (in-depth) demographics information was not recorded in the feedback and validation study. However, participants were similar to those in previous study cohorts in terms of location, age, gender, occupation and education, income and cultural affiliation. Recording forms were simplified to ensure the process was as natural as possible and time effective to encourage maximal engagement.

Participants involved in the feedback process conceded that the summary information was presented in a clear, concise manner. Furthermore, that the information was accurate, culturally sensitive and very useful to agencies and communities. During the feedback and validation process, respondents gave further interpretations and additional information related to the research questions. More detailed results from Study 3: *Feedback and Validation of the Research Findings* can be found in Chapter Ten in Section Three: Findings. The feedback and validation phase was essential in determining the validity and efficacy of the research results and methods. Ultimately, the feedback and validation phase kept agencies and community people engaged and increased their ownership of the project. This was essential for their continued involvement in the next stage of the larger project - to develop, implement and evaluate the interventions identified in this research.

6.5.2 Quality of the Data: Reliability and Validity

Many methods were employed throughout the research to ensure the quality and authenticity of the research aims, methods, data and interpretations. The author spent 3 years immersed in Broome and Ardyaloon Community life which contributed to an in-depth understanding of the issues impacting on young Aboriginal people, their families and communities in the West Kimberley. Time spent with Elders and other remote community people, including participation in cultural activities facilitated a greater understanding of the research context (e.g., history, culture, socio-political situation). Being guided by the project advisors, Project Advisory Group, community reference people and project assistants ensured the aims, methods and outcomes were relevant and meaningful to local people. The employment and involvement of local Aboriginal people as interviewers, transcribers and reviewers contributed to the

authenticity of information being generated and interpreted. The research involved several methods and sources for generating and corroborating data which contributed to the reliability and validity of the research information (Creswell, 1998). Verification of the author's interpretations of the data via the cultural validation process (Study 3) provided evidence of the (cultural) validity and usefulness of information obtained and interpreted in this research. Overall, the iterative-generative-reflective process embedded in the methodology (Bishop, Sonn, Drew & Contos, 2002) meant that ongoing consultation, interpretation, critical reflection, formulation and reformulation of objectives, methods and outcomes could occur throughout the project, which increased the reliability and validity of the research information and methods.

6.6 Conclusion

In conclusion, the methodology employed in this project had significant implications for the overall utility and benefit of this research. Specifically, the research approach meant that the aims, methods and outcomes were informed by the aspirations and contextual/cultural understanding of the Aboriginal people involved. The agency and community people engaged in identifying problems and finding solutions to deal with community problems on their own terms, according to their own knowledge and experience of what was likely to promote the social and emotional wellbeing of their young people, families and communities.

SECTION THREE:

FINDINGS

CHAPTER SEVEN

OBSERVATIONS AND REFLECTIONS ON THE RESEARCH PROCESS

As part of the approach to the current research, observations and reflections were made about the research methods and processes, recorded as field notes. The outcome of this reflective process guided further planning and implementation of the project with agencies and communities. In particular, this chapter outlines the observations and reflections made throughout the project, related to the engagement of agency service providers and Aboriginal community representatives in the current research.

7.1 Engagement of Agencies and Aboriginal Communities in the Research

It is well documented that Aboriginal communities are best placed to deal with their own problems. However, for individuals and communities to be self-determining in solving community problems, they must possess the necessary motivation, resources and skills (Pearson, 2000). An overarching goal of this project was for Aboriginal and non-Aboriginal agency service providers and Aboriginal community representatives to engage with the researchers and the project, to increase local ownership and direction of the project. The engagement process aimed to foster self-determination and strengthen capacity, in order to tackle the social and emotional problems impacting on remote Aboriginal youth, families and communities. In short, local engagement was pivotal to the project's success. Without the involvement and direction of local Aboriginal people, there would be no project.

From the earliest consultations with agencies and Aboriginal communities it was apparent that engagement of local people in a mental health promotion research project such as this would be a huge challenge. The very notion of research is representative of "White" colonialism and all that it has undone for Indigenous society, leaving an untreated mistrust of "outsiders" and their associated institutions (Smith, 1999). On the whole, people were apprehensive about being involved with outsiders, particularly non-Aboriginal researchers/psychologists. In initial discussions about the project, the general attitudes and feelings conveyed to the author were apathy, hopelessness, mistrust, hostility and at times outward anger. It seemed local people were frustrated with outsiders coming up from Perth or elsewhere, proposing to "fix" community problems with yet another proposed program, research project or service.

The local experience of research and some government services was negative, due in part to lack of consultation, poor feedback procedures and little direct benefit to the Aboriginal people involved. On observation, the methods employed by outside workers usually involved driving or flying into remote Aboriginal communities with minimal prior consultation. Workers attempted to cover several communities in a few days which left limited time to adequately build alliances and understand the needs of the community. The community was then expected to adopt the proposed program, policy, or service. In general, projects were devised with metropolitan populations in mind without direction from local Aboriginal people. These interventions had relatively short, targeted funding requirements (6 months to 3 years) and unrealistic goals (e.g., expectation of implementing and evaluating interventions within 6 months, covering too many communities, no funds to employ

local people on an ongoing basis). Thus, projects did not translate well "on the ground" in communities such as One Arm Point. Initiatives failed to get past initial consultation or discussion of problems before the funding ran out. Local people expressed concern that too few research studies or interventions focused on finding solutions and implementing these solutions with communities. There seemed to be lack of coordination amongst different agencies, research, and projects resulting in duplication and confusion for communities. Therefore, it was not surprising that many outside and government agency interventions failed, contributing to the strong disillusionment and scepticism observed in local agency and community people.

Most Aboriginal people consulted as part of this research had directly experienced inappropriate and at times abusive dealings with non-Aboriginal people throughout their lives as a result of punitive government policies (e.g., segregation, missions) and culturally inappropriate interventions. These experiences shaped early feelings of mistrust, anger, and powerlessness. The recurrence of negative experiences with non-Aboriginal people compounded this disempowerment and distress, leaving people overwhelmed and indifferent, or, rightfully protective of their "mob", with a strong resolve to do things *their* way.

Some of the non-Aboriginal people consulted also displayed a sense of frustration toward outsiders, and protectiveness of their work with local Aboriginal people and communities. Agency service providers had worked tirelessly to mend poor relationships with Aboriginal people and work in culturally sensitive ways with Aboriginal-directed agencies and communities. They did not want this hard work undone by outsiders. These service providers, like their Aboriginal counterparts, had

seen many well meaning people embark on research/interventions without meaningful consultation or collaboration with agencies and Aboriginal people, some bringing more harm than good to the local people. For people representing social and emotional wellbeing agencies and those from Aboriginal communities to engage in this research, the author and colleagues had to prove that they (and the project) would be "in it for the long haul" (S. Carrigg, personal communication, 2002) and work under the direction of local agencies and communities.

7.1.1 Reflection 1: Building Trusting Relationships

When I began work on this research in Broome, being a newcomer, young, White, female, a researcher and psychologist, I potentially had all the possible biases working against me in terms of establishing relationships with local agencies and Aboriginal communities. I knew this process would take time. As in any meaningful relationship trust had to be earned. It was important for me to set any agenda aside and allow the template for establishing and building relationships to be set by local Aboriginal people. This meant connecting with people on their terms, rather than in the prescribed role of researcher or psychologist (Vicary, 2002). However, some of the prior skills gained in these roles assisted me in this process. Consultation about the project was more about building relationships than outlining major objectives or goals, although it was important to be clear on those also. Discussions involved taking the time to listen to peoples' stories without judgement and being empathically attuned to their struggles, pain, hopes and aspirations for their young people. Listening to all those wanting to tell their story and recognising that personal accounts of the past - living

on the fringes in Derby and being overcome by alcohol, or the present - losing young people to suicide, were all relevant to understanding the lived experience of local Aboriginal people. It was important to find ways of tuning into and listening to the young people even when they seemed hostile, "shame" or quiet. This included, debunking their myths about psychologists and mental illness so they would feel less shame about expressing their worries; working alongside Aboriginal youth workers who helped bridge the gap between the young people and the researchers; and involving young people in decision making, taking direction from them and valuing their input. All of this contributed to building trust, faith in us and the project, and in turn increased the engagement of young people.

Meaningful connections were made by allocating plenty of time to spend in the community and with agencies (Trudgen, 2000). This included, continued consultation with agency service providers and community people, and listening to people's stories during two rounds of interviews and the feedback phase. Being invited into people's lives, firstly through their stories, then via cultural and community activities further solidified relationships and trust. It was important for the community, particularly the Elders, to teach me their culture and for me to be open to this learning. This included going on trips to Sunday Island and to family "blocks" where I was shown Bardi country, the places some of the old women were born, and the remains of the Sunday Island Mission where they were schooled by "White-fellas". Other experiences included spending time sitting on the beach under a bough shed, by the fire, where I was taught Bardi language, even though I spoke it badly

and managed to mispronounce a word so it sounded like some part of female genitalia (much to the amusement of the old women!), eating goorlil, cooking damper, dodging sharks at Middle Beach, and learning to throw a boomerang (embarrassing myself yet again). In most relationships there is a division of roles. In my relationship with the Elder women, I fulfilled the typical role of a young woman in Bardi culture. This meant respecting my Elders, and taking care of the older women, sharing food with them, fetching them cups of tea and generally checking up on them when I was in the community. These experiences and many more were all part of building and nurturing relationships with community people.

Within these relationships, sharing stories and "bush trips", I was able to be a part of journeys of healing. For the older women, going back to their birth places, for some of the men revisiting their past and expressing their concerns about the community through their stories, seemed to give them strength and renewed hope for the future. The research relationships provided a safe platform for people to articulate their personal struggles and aspirations and have their feelings, views and experiences validated, sometimes for the first time (Atkinson, 2002). Elders became more invigorated to impart their culture. Where activities and stories were shared as a group, family and community relationships seemed to be strengthened. Young people had the opportunity to connect with parents and Elders who began to listen to the young people and show their support.

Taking time to build trusting relationships was an essential ingredient in the engagement of agency and community people in this project. When engagement was more tenuous and people were avoidant, or openly hostile, it usually indicated a lack of trust, in us - the researchers, or White-fellas in general. Therefore, more work was needed to build trust and reach a shared understanding, and for some this took the duration of the project. When it was time for me to say goodbye, it was important to prepare the agencies and community for a potential loss of relationship and loss of continuity in project workers. This meant introducing the new Project Coordinator to agencies and the community well before my departure. It was a huge benefit that the new worker had worked for several years in Broome and already had strong ties to many local people.

In all the relationships established during my time working with Aboriginal people in Broome and One Arm Point, I attempted to be as open and transparent as possible to avoid any misconception; to listen and learn; show respect and empathy; and offer knowledge and skills when this was requested. In return I was shown acceptance, tolerance, respect and trust, and I was taught a great deal. These relationships provided the necessary base from which to acquire a shared vision and motivation to work towards the goals of the project, promoting the wellbeing of young Aboriginal people.

7.1.2 Reflection 2: Working Within Aboriginal Structures and Processes

The literature outlines the importance of working "Aboriginal way", in line with Aboriginal processes, in collaboration with Aboriginal-directed

agencies and groups (e.g., Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2000; Crawford, 1989). When I began this research in Broome, the whole idea of working with Aboriginal agencies, groups and communities was confusing and daunting. I was an outsider, looking in on someone else's world and ways of knowing. I felt displaced, isolated, frustrated and at times overwhelmed. I found myself wondering, "What am I doing here, there is no place for me, or this research". An Aboriginal person must experience similar feelings when attempting to navigate White systems and processes (Trudgen, 2000). Firstly, it was important to work out what the structures were; who were the key players; what was the role of a community council, an Aboriginal community controlled health service, Aboriginal ethics committee, a women's group, and how was I to work with these structures, what processes was I supposed to adhere to (Wettinger & Westerman, 1998b). It was helpful to seek many perspectives on these questions, read about their functionality, observe others working with agencies and communities, talk to local Aboriginal people about how non-Aboriginal people should work more collaboratively with them. I worked with these structures in an evolving way, as there was no written or openly articulated guide. I took direction either overt or subtle on how to follow protocols and processes. I found reputable people within these agencies or groups to guide me on appropriate procedures. I sought many opinions in order to follow the agreed way of working. Reflecting with a trusted colleague (e.g., the Project Consultant) was also valuable, when I could not work out how to proceed, or what I may have done wrong (Walker,

McPhee & Osborne, 2000). This helped to renew my confidence and plan a way forward.

It was necessary to appreciate that these structures function on few resources, have more demanding priorities than a research project, may cease operating for a time, or frequently change personnel. For example, in the lifespan of this research, the State Aboriginal ethics committee temporarily disbanded, the community CEO and administration staff changed several times, the community women's group was non-operational and the Council's time was taken up dealing with community administration and crisis. Regardless of these challenges, it was important to persist in working with these structures, stick to the processes and maintain a continual presence. At times, this took the form of maintaining relationships and providing ongoing feedback to individuals within these structures rather than the whole group.

A valuable lesson learned was to understand the local politics in organisations; their power struggles, internal conflict and alliances amongst individuals, agencies and groups. This included the historical origins of relationships, or lack thereof, between local agencies (both Aboriginal and non-Aboriginal directed), communities and family groups. Remaining neutral was key to working collaboratively, and with several agencies, groups and families, rather than an allied few. On reflection, I found that when working with Aboriginal controlled agencies and groups, it was important to be prepared for the tough questions; to know and justify my role and be

challenged on my intentions, not once but several times. It was important to be clear about project parameters – affiliations, funding, objectives, possible outcomes, and how this could complement not duplicate or undermine what these groups were trying to achieve. Furthermore, to be mindful and patient that some of these agencies and groups are developing their processes, for building partnerships with outsiders, for tackling complex community problems, in their own way, and this takes time. I also observed that there is an equally strong and valuable opinion outside these structures (i.e., amongst other community people, service providers). This needed to be considered through wide consultation and the formation of a network of project advisors as opposed to being guided by one agency or group (Burchill, 2004).

Overall, I recognised the need to reflect on and learn from my mistakes, to keep trying to establish working relationships, despite the challenges or when the connection seemed to be lost. I learned to work with Aboriginal structures and adhere to Aboriginal processes, even when they seemed very different to my own. As I experienced throughout this research, the goals of the project were reached, even though it took a less familiar path to get there. The result was that people engaged in the research, they directed the process and shaped the project. Therefore, the research was viewed as relevant and meaningful to their situation. Local people also engaged with the project workers, both guiding us and seeking our knowledge and skills. As a result of this engagement and collaborative work, the project became embedded in the existing local structures and processes. Aboriginal structures, and processes

for working with non-Aboriginal people to tackle local problems were maintained and strengthened, building local capacity.

7.2 Sustainability: Building Capacity in Agencies and Aboriginal Communities

7.2.1 Sustainability

A concern commonly articulated by local people to the author was about the longevity of the researchers and the project. Agency and community people wanted to know: *How this project would be sustained in remote communities? What would happen when the funding ran out? What would happen when the researchers left the community?* Given the entrenched nature of problems and lack of infrastructure and resources in Aboriginal communities, it was essential to begin this project with a long-term view on sustainability. The main mechanism for sustaining the project into the future was for the community to take ownership and responsibility for dealing with youth and community problems (Mitchell, 2000; Pearson, 2003).

Like many remote Aboriginal communities, the communities consulted during the current research were ill-equipped to fulfil this task on their own. For example: community people were seen to be "burnt out" with the day-to-day running of their families and community; they experienced a high level of family and community conflict and resulting disconnection, which made it very difficult to unite and take action to help young people; the young people appeared marginalised and felt hopeless and helpless, they received little support and had few resources at their

disposal to initiate change. In general, residents of the community were disengaged and disempowered and unable to bring about change by themselves.

Community problems were longstanding and entrenched. Solutions were crisis driven and short-lived. There was a general attitude that someone else would fix the problem. Infrastructure for youth activities was poorly maintained. Structures and programs, such as the women's group, recreation officer, and Youth Project had long been disbanded. Funding for young people was unallocated. Services were based in town, 3 hrs from One Arm Point. Agencies were limited in what they could provide remote communities due to lack of resources. Amidst competing community demands, dysfunction, and lack of resources, it was apparent that it was virtually impossible for the community to define youth problems, generate solutions, carry out and evaluate these solutions without significant, ongoing outside support. This did not mean the community, including the young people, did not have the knowledge and skills to tackle internal problems, but at that point of time it was a massive undertaking. The community required outside facilitation to assist in this process, to build capacity in order to prioritise problems and solutions and importantly sustain community solutions into the future.

7.2.2 Capacity Building

A second overarching goal governing the current research was to build capacity in agencies and the community. This meant providing opportunities for local people to gain motivation, knowledge, expertise and skills in community-based mental health research and intervention relevant to their agencies and communities (Gordon, Hallahan & Henry, 2002; Smith, 2005). The first part of this process was scoping

local resources, including available people, knowledge, skills, funds and infrastructure (Eckermann et al., 2006). It was apparent despite the resource shortages, that there was vast local knowledge and expertise, as well as a shared dedication amongst agency and community people, for working to improve the lives of Aboriginal people in the region, particularly young people. Effective work with Aboriginal people relied on local knowledge. The author, being new to the area had much to learn. In working towards building local capacity, the author and colleagues worked collaboratively with service providers and Aboriginal people in communities. It was through this collaboration that skills, knowledge, expertise and resources were shared between the researchers and local people.

For the community to build its resources and expertise to deal with youth problems and promote wellbeing, community people needed to define the problems and generate the solutions. This development needed to occur in stages. Consultation, and two rounds of interviews and discussion groups, as well as the feedback and validation phase enabled deep reflection on the problems facing the community and what activities and strategies would be best to deal with these problems. Allowing plenty of time for discussion and reflection meant that information and ideas were consolidated and people reached a heightened understanding of their situation. This increased motivation, mobilised existing ways of doing things, and generated fresh approaches. This process built existing capacity and created new knowledge and skills. The involvement of outside agencies in the research also increased the community's capacity through linking communities to agencies, building partnerships with agencies and relationships with service providers who visited the community as part of the project. Enhanced relationships with agencies resulted in

increased resources (e.g., funds for activities, workers to assist with activities), knowledge and skills from agencies. In turn, agencies benefited from learning more appropriate and therefore effective ways of working with remote Aboriginal communities.

The employment of Aboriginal project assistants also contributed to building capacity in the local area. However, there were some barriers to employment and retention of project workers, as follows:

- Low availability of workers skilled in research and intervention.
- Skilled workers already over burdened with work, community and family responsibilities.
- Community Development Employment Projects (CDEP) and welfare payments can be affected by doing additional work.
- Hard to distinguish between what should be paid work and family and community responsibilities for which people would not usually expect payment.
- The need for male and female workers to work with the same gender so a greater number of workers are required.
- Young workers find it hard to work with older people due to the position in the relationship so a greater number and variety of workers are required.
- Employing people from the community can decrease confidentiality and therefore participation in the project.

- Employing people from outside the community can decrease trust and therefore participation in project.
- Some community people find it hard to work with relatives/kin, especially on sensitive issues.
- Formal contracts and timesheets aren't appropriate and need to be adapted.
- Workforce is transient.
- Workers can experience negativity about working for non-Aboriginal people or outsiders.
- Workers become overwhelmed and do not seek support.

Despite these challenges, several Aboriginal project assistants were employed and one Senior Aboriginal Project Assistant was retained for 2 years. Workers and project advisors had enormous amounts of local knowledge to offer which educated the researchers and impacted positively on their work with Aboriginal directed agencies and remote Aboriginal people. Project assistants also required significant training in mental health promotion research and project intervention. Supplying ongoing support, mentoring and access to professional development activities (e.g., workshops) were useful capacity building strategies and aided in retention of project assistants. As a result of increased capacity, the Senior Project Assistant, and the Youth Workers assisting with the project were able to advance their study or employment options after their work with this project, keeping valuable knowledge and skills in the region.

7.2.3 Reflection 3: Towards Community Action

When I first wandered around One Arm Point in 2002, I did not see many older youth, they seemed to keep themselves hidden away, watching TV, sleeping in until late after being out all night. When they did emerge, they walked around in small groups with their heads held down, they kept to themselves, like they had done something wrong, like they had nowhere good to go. Those who had CDEP jobs seemed a little more optimistic but I learned from talking with them that, like their peers, they were overcome by the problems surrounding them. When we began to ask about the wellbeing/"liyan" of the young people, their parents and Elders conveyed frustration, "these young people, they…lazy, bored, smoke 'gunja', drinking, don't go to school, don't work, no respect". For the most part, they were concerned. They told me young people needed help, "lots of fighting, parents drinking, nothing for them to do, no jobs, no future". They feared for some of them, as the community had experienced several suicides. The trauma was very real, there was a lot of grief, anger, pain and sadness. Then we asked about what types of things the community did for young people. There was a lot said about the past, "we used to have football, we'd go to Broome every week". "Us mob, we'd go fishing, all cook up feed, share it around". "We had a 'rec' officer, we haven't had one for a few years". It seemed a lot had changed for the young people. I looked at the football oval, it was overgrown, apparently no grounds people to look after it. I asked about the recreation officer position, funds were available but the last worker got burnt out from too many "put-downs" and no-one had put their hand up to do it since. What about families, sitting on the beach together? By all reports, no-one had done

that in a long time, "too much fighting". It appeared that the community had given up on the young people, and in turn the young people had given up on their community.

Although the community was immobilised and unable to take direct action themselves initially, they were willing to talk about the problems and possible solutions, which was a first step towards being empowered to take action. Due to the disconnection of families and young people in the community, a lot of talking was done initially in separate groups rather than as a whole community. People needed to share openly and comfortably their perspective on difficulties in the community and the origin of these problems. Feeding back information from community consultation and interviews on an ongoing basis was important. It allowed community people to know that they were not alone, their concerns and hopes were shared amongst others in agencies and the community. The community, especially Council, parents and Elders spending time with us, voicing their concerns, gave the youth some tangible evidence that their community cared about their wellbeing and was willing to provide support. The momentum for engagement increased significantly after feedback from the first round of community interviews (defining problems). This saw increased involvement of community people, particularly older youth (now more trusting of the researchers and the process) in the next round of discussions about generating ideas on ways to build strengths and promote the wellbeing of young people, their families and the community.

The end of 2003 was a turning point, from talking about problems and solutions to the community itself initiating one of the proposed community activities. The information given by the community in interviews was discussed in groups as part of community feedback. One of the priorities for the community to improve wellbeing was that the community would "come together as one, sharing culture amongst families". During this community visit, discussion intensified among some of the Bardi Elders, to gather some of the "dancers" together, plus the young boys, have the older men "paint them up", and tell everyone to come down to Middle Beach for a BBQ and "Ilma" ceremony at sunset. We offered to pick up the old people, provide some funds for food and spread the word. More people started talking about the BBQ and coming together, importantly the Council thought it was a good idea. We dropped some people at the beach, young people started coming down, excited. Some of the older girls offered to help feed the kids, and supervise "dodge-ball". An old man, very frail, who hadn't been at the beach for a long time spoke about the "old days" while he looked fondly out to sea. We all made our way to where some Elders assembled with the young men and boys, the Bardi dancers. There must have been about 60 people from all the different family groups. We sat mesmerised for over an hour, with the sound of boomerangs clacking, the old people singing in Bardi. The dancers stamped their feet in the sand with the sun setting behind them. The little boys danced too, wide-eyed, less assured of their moves but following the older boys intently. The old people said they could have sung all night, they were leaders, energised and proud. As for the young people, some had not seen their community sharing time and place together for a long time, if at all.

They had renewed faith, some purpose, they felt connected. This was another small step in the overall engagement and capacity building process, a step towards community action.

7.3 Summary

An outcome of the research process and methods was increased agency, community engagement and capacity in working to define and provide solutions for youth and community problems. Many processes and methods were utilised to engage local people, including young Aboriginal people in this research. The engagement process aimed to be empowering for local Aboriginal people to participate, provide direction and take responsibility and ownership of tackling their own problems, in their own way (Mitchell, 2000; Pearson, 2003). To summarise, recommended strategies for increasing Aboriginal engagement and capacity building (seen in this and other related research) are outlined below. These methods encourage self-determination and aid in sustainability of processes/interventions to combat social and emotional problems in remote young Aboriginal people and communities.

<u>Engagement</u>

1. The research/intervention must be community-based whereby local communities and agencies prioritise and define objectives, methods and outcomes so these are culturally sensitive, relevant and beneficial (Mitchell, 2000).

2. Spend time building and maintaining trusting relationships and equal partnerships with agencies and communities, including learning local culture and history (Trudgen, 2000, 2004).
3. Work with fewer communities more intensively as opposed to several communities.
4. Work within Aboriginal structures and processes (AIATSIS, 2000).
5. Collaborate with several agencies/groups, incorporating different and shared ideas on ways of working (Crawford, 1989).
6. Be guided by a network of advisors representing agencies and the community rather than just one agency or group.
7. Be guided by cultural consultants/reference people (Vicary & Bishop, 2005)
8. Use an iterative-generative-reflective process to define and prioritise problems and solutions (Bishop et al., 2002), characterised by ongoing consultation/discussion, interpretation, feedback, reflection.
9. Provide ongoing, transparent feedback (Hunter, 1992b).

Capacity Building

1. Scope and utilise the existing resources (e.g., knowledge, skills, funds and infrastructure) in agencies and the community. Offer resources, knowledge and skills when required (Eckermann et al., 2006; Tann, 2002).
2. Assist the community coordinate and facilitate their approach instead of directing the goals and approach.

3. Promote community participation/involvement through wide consultation, ongoing discussion, feedback and reflection.
4. Employ local Aboriginal people (Smith, 1999; 2005). Provide training, mentoring, ongoing support, professional development activities.
5. Link the community with outside agencies and groups.
6. Support, work with local agency and community structures and processes to promote leadership and management (Gordon et al., 2002; Pearson, 2000).
7. Train the community in funding applications, funding administration.
8. Allocate plenty of time to all of the above.

CHAPTER EIGHT

FINDINGS

STUDY 1: PROBLEMS, RISK AND STRENGTHS

Study 1 involved interviews with 20 participants from Broome and 38 from Ardyaloon Community, One Arm Point. The aim of Study 1 was to describe the mental health and social and emotional problems affecting Aboriginal children and youth living in remote communities in the West Kimberley. This included: (1) types of social and emotional problems; (2) signs and symptoms shown by youth experiencing problems; (3) coping strategies; (4) risk and protective factors, as well as; (5) definitions of youth wellbeing and resilience. The first part of this chapter outlines the main findings from Study 1. The themes and sub-themes for each of the interview questions are provided in sections corresponding to the study aims. Results are summarised in tables for ease of reference. The second part of Chapter Eight conceptualises pertinent findings related to the main problems, risk and resilience factors reported to be impacting on youth and community wellbeing. Extracts from original interview transcripts are given to further exemplify the findings. Permission was obtained from participants at the time of interviews for this use of interview information.

8.1 Social and Emotional Problems in Remote Aboriginal Children and Youth

Interviewees from Broome and One Arm Point were asked to define the types of problems impacting on Aboriginal children and youth living in remote communities.

Question: *What sort of social and emotional problems (hard times) do young people in this community (remote communities) have to deal with?*

Problems were identified at the individual youth, family, community and societal levels. Youth problems were further categorised into sub-themes, such as social, emotional, educational and cultural issues. Problems reported to be affecting remote Aboriginal children and youth are presented in Tables 6 and 7.

Table 6. *Problems Affecting Remote Aboriginal Children and Youth*

Social	**Emotional**	**Educational**	**Cultural**
Alcohol misuse	Depression	School drop-out, truancy	Difficulty coping with both Aboriginal & mainstream cultures
Cannabis misuse	Grief & loss	Poor literacy & numeracy	Breakdown & loss of culture
Abuse - sexual, physical, emotional	Anxiety	Homesick when away for schooling	"Wrong-way" relationship
Neglect	Suicide		
Domestic violence	Trauma		
Family fighting	Psychosis		
Bullying	Identity confusion		
Poor social skills	Low self-esteem		
Peer pressure	Boredom		
Juvenile crime			
Early sexual experiences			
Teenage pregnancy			
Early parenting			
Sexual health problems			
Relationship breakdown			
Lack of privacy			
Homelessness			
Unemployment			

Table 7. *Family, Community and Societal Problems Affecting Remote Aboriginal Children and Youth*

Family	**Community**	**Society**
Alcohol misuse	Lack of youth activities	Impact of colonisation &
Cannabis misuse	No recreation officer	government policies:
Family fighting	Poor recreation facilities	Removal from land
Domestic violence	Few paid jobs	Mission/institution
Death of loved ones	CDEP – no incentive	upbringing
Suicide	to work	Breakdown of culture:
Parent separation	Lack of access to training	language, Law/governance,
Family breakdown	Loss of Elder leadership	kinship/care system
Breakdown of extended	Breakdown of traditional	Welfare dependence
family system for caring	Law to manage problems	Impact of Western culture:
for children	Few local role models	Individualism
Gambling (playing cards)	Loss of traditional roles/	Materialism
Financial hardship	identity	Influence of American
Poor financial management	Community fighting	Culture:
Unsafe home	Disconnected community	TV, DVDs, rap music
Overcrowding	Social isolation	Racism
Harsh discipline	Lack/mismanagement	Discrimination
No boundaries/discipline	of funds	Stigma about mental illness
Lack of family support	Limited access to outside	Unequal outcomes for
Generation gap between	agency support	Indigenous vs
old and young people	Lack of responsibility &	Non-Indigenous Australians
Unemployment	support for young people	
Crime/incarceration	No youth “safe” place	

Broome and One Arm Point participants did not differ in their reporting of the main problems making life hard for remote young Aboriginal people. Respondents reported the same five main problems as follows: (1) alcohol and cannabis misuse and dependence, (2) family fighting (includes domestic violence), (3) lack of community-based activities and opportunities contributing to boredom, (4) suicidal behaviour and (5) sexual abuse. Other problems commonly reported were: neglect, death of a parent/carer or close family member contributing to grief and loss, education difficulties (e.g., truancy, school drop-out, low literacy), breakdown and loss of culture, unemployment, lack of family and community support, juvenile crime (e.g., vandalism, break-ins, stealing), bullying, and gambling. Some examples:

Alcohol and Cannabis Misuse

> *"alcohol and drugs are starting to become major influence in the community or major problems in the community and it's causing not only problems with the kids, but I suppose the wider community as well, the adults, parents, grandparents, you name it."* (Male, 36 years, One Arm Point)

Family Fighting and Violence

> *"I would have to say that probably domestic violence is pretty bad and all the kids are involved in that. Whether they are sixteen or five or whatever, there's a lot."* (Female, 47 years, One Arm Point)

> *"I think there's well domestic violence going on around the community but I think the biggest problem is in the community itself, is families disputing against families and that's making themselves, the young ones basically stick up for their parents and carrying on this community conflict."*
> (Male, 36 years, One Arm Point)

Lack of community-based recreation activities and work, training opportunities for young people contributing to boredom.

> *"Well lack of um, there's not a lot of sporting or sort of after school recreational options apart from, you know, going out fishing, and down the beach and things like that. There's no like set organised sports, apart from*

the Easter Basketball Carnival, or in the past I've run student council basketball competitions after school. But um really the community should have a recreation officer to do things like that for the kids, and that can involve older kids, you know, 16 down to 10, you know, 10 years old. And also another problem I reckon is lack of real employment apart from CDEP type jobs. There's not a lot here, not like you know, there's a lot more in Broome or I used to live in Fitzroy Crossing, there was a lot more options there, whereas at One Arm Point you've really only got the store, the school, working down the hatchery, um, so there is a limited number of jobs you can probably do, apart from CDEP jobs." (Male, 43 years, One Arm Point)

"I find it boring, nothing much to do. It's real hard for that age. They just sit around wasting their lives you know, drinking. So I'd say yeah from 17 to 20 are the one's that there is nothing here, out here for them."
(Female, 18 years, One Arm Point)

Suicidal Behaviour

"Ah, I know of some people that have tried to commit suicide, some of the older ones that are in their mid, mid-twenties to mid to high twenties that have committed suicide. There's been a few here since I've been here and normally before they do that there are signs that they're not happy - where you know they'll do something that makes people, you know, draws attention to themselves really obviously." (Male, 43 years, One Arm Point)

Sexual Abuse

> *"I think there could be, as I said, could be an underlying issue with molestation I suppose in this community for young kids, you know. Unfortunately when you have it in an Aboriginal community, there is something like that going on but parents fiddling 'round, mucking 'round with child, young kids, molesting them. They try to hide it, they're embarrassed, they don't want to bring it up, it's gonna cause 'em another big problem. I suppose, accusing somebody else, whether it's true or not, but again I'd say, it's community-wide, It's Peninsula-wide. All over I'd say. A lot of people just hide it."* (Male, 36 years, One Arm Point)

Neglect and Gambling

> *"I mean some children have been neglected as a result of their parents just playing cards all night. They don't even have to be drunks. They don't even have to be druggies or whatever, or they just um their parents could be playing cards all hours of the night and they will play until the early hours of the morning, won't they? Therefore, the kids are either sleeping next to them somewhere or they are just wandering around while their parents are playing cards."* (Female, 23 years, Broome)

There was little difference in reporting of problems amongst parents, carers, youth, Elders and service providers from Broome and One Arm Point. Parents, carers, service providers and young people reported that suicide, the death of a parent, carer

or other close family member, and sexual abuse were amongst the five main problems. All youth interviewed from One Arm Point highlighted fighting amongst family groups as one of the most difficult problems they had to deal with. Parents and older people from One Arm Point reported that breakdown of their culture, including the negative impact of past government policies and the more recent influence of Western/American culture, to be one of the most significant problems impacting on young people, families and the community. For example:

> *"You got your DVDs, your videos, your TVs, your stereos, all them gadgets. Then you got you know you got your pubs, you got outings where people go and you got alcohol in there, you got drugs and things that affect everybody too."* (Female, 32 years, One Arm Point)

Female Elders noted that teenage pregnancy, early parenting and sexual health issues (e.g., sexually transmitted infections: STIs) presented problems for youth in their community. Service providers working and living at One Arm Point reported that education difficulties, such as leaving school early, truancy/poor school attendance, low reading and writing skills, as well as social isolation and poor social skills posed significant problems for remote young Aboriginal people. For example:

> *"Most of the kids don't go to school, especially the older kids. I mean, I was up at the school today, and in the high school, which is grade 8 to grade 12, there would have been seven kids at school. That's it."*
>
> (Female, 47 years, One Arm Point)

There was consensus from Broome participants that the most debilitating problems affecting the wellbeing of remote young Aboriginal people were alcohol and cannabis misuse and dependence, and family fighting. Parents and carers interviewed from Broome perceived that lack of community-based activities and opportunities, as well as suicide, and grief and loss resulting from the death of a parent, carer or close relative, were among the most difficult issues facing remote young Aboriginal people. Service providers reported that abuse (e.g., sexual, physical, emotional) and breakdown of culture were also main problems. Broome youth identified bullying and teasing to be a significant problem for young people. Many participants from Broome reported that accommodation issues, such as homelessness or overcrowding posed a difficulty for Aboriginal youth. Parents, carers and service providers from Broome reported that racism and discrimination were also problems that made life harder for remote young Aboriginal people. For example:

Death of a parent/carer or close relative

> *"I think there's a huge impact on families up here when someone dies. It's so close to home…But up here everything's personal and I think that's because family connections, small population and things like that. So yeah it does have a huge impact. It's very hard when there's been a suicide or a death, a young death, um you know, you're on watch, you're on guard because you're watching the young fellas that knew that young fella or the young people that knew that person, and you try to figure out who might be at risk, and try to get people to keep an eye on them and things like that. Um yeah, a huge impact."* (Female, 42 years, Broome)

"I think it's also important to mention too we're not talking about older people dying, we're talking about you know people in their 50s dying of diseases of neglect, diabetes related stuff and heart disease, but also incredibly violent deaths, you know like car accidents, that kind of thing that happens. So it's not just kids are dealing with death more often, but the nature of that death is like pretty full on itself. You know, people shouldn't be dying at 50 routinely, and in really violent car accidents, and those things are definitely a factor of being Aboriginal in an Aboriginal community, which I think is really wrong, and I think it would be very hard to escape that mindset, whether they are aware that these things happen more to them than they do in the general population." (Female, 31 years, Broome)

8.2 Signs and Symptoms

Participants were asked to think about a young Aboriginal person living in a remote community who had significant mental health and or social and emotional problems, and from what they observed describe the behaviours, thoughts and feelings of that young person.

Question: *Can you think of a time when you knew a young person was dealing with something really hard. How did they act? What were they thinking to themselves? How were they feeling?*

The signs and symptoms identified by participants were categorised into three groups: behaviours, thoughts and feelings, listed in Table 8.

Table 8. *Signs and Symptoms to Recognise in Remote Aboriginal Children and Youth Experiencing Social and Emotional Problems*

Behaviours	**Thoughts**	**Feelings**
Sudden change in behaviour	Low self-esteem	Angry
Unkempt appearance	Poor self worth	Moody
Increased drug &	Believes "no-one cares	Sad
alcohol misuse	about me"	Anxious
Withdrawal from friends,	No future goals –	Fearful
family, school, work	negative view of the future	Lonely
Socialising with	Loss of direction – negative	Isolated
antisocial peers	view of current situation	Frustrated
Fighting	Concentration problems	Bored
Picking on others	Hallucinations	"Shame"
Talking "silly"	Helplessness	Worthless
Goes quiet	Hopelessness	Prolonged grief
Talks of "I hate myself"		Fear of leaving
Very secretive		family, community
Not sleeping		Scared of being "sung"
Sleeping too much		or others being sung
Not eating		Confused
Self-harm		Powerless
Suicidal ideation, attempts		
Upset stomach, headaches		
Lack of energy		
Low motivation		
Break-ins, stealing, vandalism		
Acts strange, out of character		
Complains of boredom often		
"Humbugs" (bothers)		
relatives a lot		
Lack of respect for self & others		
Lack of self responsibility		
No future goals		

Respondents from Broome and One Arm Point predominantly reported that young people showed they had a problem by withdrawing or acting out, or a combination of both. For example:

Withdrawing from friends, family; disengaging from school, work, recreational or cultural activities.

> *"you could say they're generally quiet, they, you know, they may not care about their appearance as much, but these are just generalisations. Don't*

care about coming to school, or don't care about going to work, just, you know, don't see them around, they're often just inside."

(Male, 43 years, One Arm Point)

"Yeah, quiet, keeping to themselves. In the playground, yeah probably sit somewhere and yeah, and not join in." (Male, 14 years, One Arm Point)

"They tend to shy away from people. They become reclusive. They withdraw. They stop doing the things that normally they used to enjoy doing, whether it be sport or music, or they don't just withdraw from family and friends, they withdraw basically from society as well. You can't have a conversation with them. Most of their answers are quite short and are not or non-responsive like you'll ask a question and it'll be a nod or a shake of the head. They find it hard to communicate. They've got no interest, they're lethargic."

(Female, 39 years, Broome)

Acting out behaviour

"*Sometimes, some kids would go off at the rest of the kids so you just let that person go out for 5 or 10 minutes and they cool down. Then you take other kids that would go off ranting for the next hour or so, and then it would be pointless having them at school. But um, yeah, yeah some kids just tend to go off but then you got, like we had some kids that were heavy users of marijuana and that, those sort of kids were just um would go for hours on end, angry at everybody, especially if they had a problem."*

(Male, 25 years, Broome)

"Oh, when I get angry I usually like walk off and yeah, just say things to myself, you know, hit something, something like that, but if someone stops me I just go off at 'em but yeah, that's my warning like walking off means I'm angry." (Male, 14 years, One Arm Point)

"Some young people take it out on the little ones. I don't know, they hit them or push them around, you know." (Female, 18 years, One Arm Point)

"Naughty things. Breaking and entering, stealing, stealing cars."
(Female, 45 years, Broome)

Withdrawal and acting out behaviour

"Well, generally they, you know, they go quiet and withdrawn from themselves, that's on one extreme and the other extreme they go the opposite, become really, you know, may drink or become loud 'round the community or do dangerous things." (Male, 43 years, One Arm Point)

Some young people reportedly demonstrated their distress through suicidal behaviours or self-harm. For example:

"She was talking about doing silly stuff to herself, you know. Like killing herself- 'nobody loves her'. She was blaming herself that it was her fault, and (thought) we wasn't worried about her or anything, you know."
(Female, 36 years, One Arm Point)

"His behaviour, violence, violent and always ah agitated. Um always talking silly, wanting to do things to himself and hurt other people. Self-harm and harm others. Um every time we would go out to help him, he'd always say to us, 'I don't need help', so he was denying he had a problem. He said 'I'm not crazy', basically he was trying to say he wasn't crazy, but all we wanted to do was help him." (Female, 32 years, One Arm Point)

Some other thoughts and feelings young people experienced:

"'I am worthless, I'm not good'. They feel very negative about themselves, feel very low." (Female, 41years, Broome)

"Lack of security really. ...[thinking] that no-one is worried about them or… No one cares. 'I'll just go do this, no-one will care about it'."
(Male, 42 years, One Arm Point)

"Yeah well they usually think the whole world's against them, like there's no-one there to help 'em." (Male, 14 years, One Arm Point)

Participants reported that in general females showed more passive behaviours, such as withdrawal compared to males who were more likely to act out their distress through aggressive behaviour toward self and others. Girls were cited as more likely to seek help by talking to someone they trusted, whereas boys were more likely to bottle-up their emotions and keep their problems to themselves. For example:

> *"Um, girls are a bit quieter, a bit different than boys."*
> (Female, 18 years, One Arm Point)

> *"Ah, yeah probably girls would be generally be more withdrawn I'd say, whereas boys might tend to have you know, show more that they're not happy."* (Male, 43 years, One Arm Point)

> *"Males bottle it up, express it when drunk, maybe explode which leads to bigger conflict. Females don't show it. Males more snappy. If they do talk about a problem they will talk to one trusted friend."* (Male, 30 years, One Arm Point)

Some respondents reported that it was difficult to identify signs and symptoms in some young people experiencing problems and a lack of awareness about what signs and symptoms to look for. For example:

> *"Yeah um, and I suppose it's more the people that you don't expect, expect it to happen and I think like you just. Like there's sometimes I've thought you know that someone might be like that but you don't really notice the signs or*

the symptoms of what you know, if that person is suicidal, unless they're going to a youth service or something and which a lot of 'em, especially older ones wouldn't really, I don't think would really do. You don't really know. Um and that, like that was like one girl here she just, she was quiet but, she was always quiet and then one day before you knew it she'd hung herself and no-one expected her to do something like that. So I suppose people just you know, here don't really, aren't aware of the problem you know, what to look for kind of thing." (Female, 22 years, Broome)

Overall, there was no significant difference in responses from Broome and One Arm Point participants or from parents, carers, youth, Elders and service providers.

8.3 Coping Strategies

In Study 1, participants were asked to reflect on what young people did in order to cope with the difficulties they experienced. Respondents were also asked to comment on what family members, friends, the community and outside agencies did to help young people experiencing social and emotional problems.

Question: *When a young person is going through a really hard time, what have you seen young people do to try and deal with their problems? What about the family, friends, community, outside agencies? What do they do to help? What did not help?*

Two broad themes were identified: helpful (positive) and unhelpful (negative) coping strategies. Helpful and unhelpful methods for coping were categorised at the individual youth, family/friends, community and outside agency levels. Results were summarised and tabled according to these categories. Table 9 outlines helpful methods for coping, as follows.

8.3.1 Helpful Ways of Coping

Table 9. *Helpful Ways of Coping with Youth Problems*

Youth	**Family/Friends**	**Community**	**Outside Agencies**
Talk to a trusted person Seek support/ counselling Deal with the problem now not later Manage anger Look after health Express feelings Think positively Look toward the future Go fishing, hunting Play sport Listen to music, write Go to a place you feel connected/belong Learn from other people's struggles Respect yourself Engage in school, work, training Leave the community for respite Think before you act Visualise positive experiences	Listen, support Give practical advice Encourage, praise Show love, acceptance Talk when sober Watch out for signs & symptoms Fair discipline Don't judge, punish Spend quality time with young person Practise culture Look after each other Provide a safe home Take young person away for respite Help seek support from agencies Be positive role models Take responsibility Respect one another Help with youth activities Come together as a family/extended family	Council, Elders show support, fund youth activities Clinic, wardens show support School – provide a safe place, support Help seek support from agencies Accept problems exist Take responsibility Come together to practise culture Practise Law Enforce by-laws Council, Elders set positive example Come together to assist in a crisis	Provide information, support, counselling, ongoing intervention Consult with council, family, youth Explain role & purpose Train workers to deal with youth problems Build trust with client/community Spend quality time in the community Promote agency & how to access services Collaborate across agencies & groups Train & support local people to run activities Respond to crisis in a coordinated way

The most common helpful coping strategies reported by Broome and One Arm Point respondents were, for youth: seeking help from a trusted person and talking about their problem; for family/friends: providing support to young people and spending

quality time together; at a community level: Council, wardens and or Elders stepping in to assist young people and families deal with more serious problems, such as family fighting or suicidal behaviour; for outside agencies: providing support and counselling to young people and families in the community. Some examples of helpful coping strategies as follows:

> *"Well probably go to someone they trust or they know they can get help from, yeah, probably close friend, close family member or a workmate."*
> (Female, 23 years, One Arm Point)

> *"Not going to put them down, humiliate them, just talk, let them talk and listen."* (Female, 41 years, One Arm Point)

> *"Um just go up to them when they are angry or when they argue with their parents, tell them, go talk to them, just calm them down, ask them what the problem is and let them know that you are there for them, you know yeah."*
> (Female, 18 years, One Arm Point)

> *"Like what with my nieces and nephew if they go through a hard time we try and go have a talk to them, well I try and go have a talk to them. Talk to them in a nice way and encourage them mmm. Like tell them if you think of talking to someone, there are a lot of people who will listen to you. You don't have to talk to someone in the community, if you wanna go away for a while you can get that help, you know. Like when I talk to them about it, we figure out where to go and who's gonna be there, and I tell them people are gonna*

listen to you. If you just go and ask for help you get it, you know. You won't be left alone. They feel much better, then they wanna talk about it more, yeah." (Female, 18 years, One Arm Point)

"I know at school we've had certain teachers that have helped kids having problems and they've felt comfortable, might not be their own classroom teacher or teachers that teach them but might be someone else – like a registrar at school or someone else working at the school that can talk to them. I know that's helped." (Male, 43years, One Arm Point)

"I find that the Council, if I ring them up, they will really try very hard to help me out. If I have a domestic violence situation that involves children or adolescence or whatever, and I ring them Saturday afternoon and say 'look I'm really worried about [name], or whatever. I think he's suicidal and I think he wants to get out', they will try very hard to help him. They will get a car, they will drive him to Broome, they will find a driver for me. But I guess that's a crisis. Um when there's a crisis on, everybody here rallies. If somebody gets sick, they'll get a car, they'll really help out."
(Female, 47 years, One Arm Point)

"like lotta girls probably have problems but they've got ways of dealing with it. I'll probably have a problem like, what I usually do is just go down to the beach and sit down and just sort of walk around just um, I don't know, think things over." (Female, 23 years, One Arm Point)

"I s'pose another one is not to do is um, you know, get on the grog and gunja. Some people might think that it helps them to get rid of the problem. You know, it just makes it worse I think. Um – and also just maybe don't sit around and do nothing you know. Sorta go out and go bush or go fishing and find something to do you know, play footy or basketball. Yeah sorta just do things to keep your mind off things." (Male, 23 years, Broome)

"Yeah, when things get bad sometimes I ask my friends for advice, cos like you can open up to them a little bit more." (Male, 14 years, One Arm Point)

8.3.2 Unhelpful Ways of Coping

Table 10 lists the unhelpful methods of coping with young people's problems reported by participants.

Table 10. *Unhelpful Ways of Coping with Youth Problems*

Youth	**Family/Friends**	**Community**	**Outside Agencies**
Using drugs & alcohol to cope Fighting with others Harming self, others Causing trouble at home, school Drop-out of school, work, study Bottle-up feelings Don't talk about problem Deny problem exists Thinking the worst Too shame, scared to seek help Seeing no way out Believing no-one can help Having no-one to trust, rely on Down on self, blames self Isolating self Don't listen to advice Run away from home, community	Fighting with young person Bullying, teasing Pressure young person Ignore, isolate, reject, growl, judge, laugh at young person Gossip about problem Giving youth drugs, alcohol Solving problem when drunk Blame family, other families Fight with other families Cover up problem Relatives not coping with their own problems Don't know signs to look for Distracted with drinking, gambling Doing nothing	Being unsupportive Deny problems exist Using culture as an excuse Not taking direction, responsibility Blame young person, their family Don't involve young person in solving problem	Lack of consult with family, community Agency role unclear to community No follow-up visit Visit too quick, unprepared Infrequent visits Untrained workers Some workers too closely related to deal with family Lack of resources Lack of collaboration & coordination amongst agencies Culturally insensitive way of working Confusing referral process Unresponsive Stigma associated with some agencies

In terms of unhelpful coping strategies, the majority of participants from Broome and One Arm Point reported that young people used cannabis and alcohol as a means of coping with their problems. In relation to coping strategies employed by family/friends, the respondents most commonly cited lack of support from family and community as the most unhelpful methods for dealing with young people's problems. Youth in particular reported that they found family members gossiping to

others about their problems to be very unhelpful and contributed to lack of trust in significant others and reluctance to seek help from family members. Some examples of unhelpful coping strategies as follows:

> *"people that I know who had problems they dealing with things with smoking gunja or walking the streets at night late or drinking. Most people I know. I'm yet to meet somebody who done something positive instead of using the grog or the gunja for that problem that they had. I'm sure most times you see somebody with big problems, if they're a gunja smoker well they'll smoke more gunja or drink more alcohol."* (Female, 41 years, Broome)

> *"Yeah, they're trying to deal with it themselves. It gets so big they can't cope with it and the way of coping with it is probably drinking more alcohol and this seems to be the trend you know. People are drinking more alcohol and I s'pose probably, you know, carrying on with drugs more, cos it's a way of coping with it. So they try and hide it, bottle it up and that's what the trend is, instead of opening up and expressing themselves, drink, it comes up, the more drunk, the more they thinking about it. So yeah, keep it bottled up all the time and things getting worser and worser, it's the cycle I s'pose."*
> (Male, 36 years, One Arm Point)

> *"Like only sometimes when I talk about my problems, is when I'm drunk."*
> (Male, 21 years, One Arm Point)

"I mean you could really trust your aunty, uncle or mum and dad but you can't, they can't necessarily relate to what you are feeling because if you are feeling a certain way some parents just say 'don't be stupid', you know, 'get over it'. 'You are acting like it's a big thing, it's not'. But really it is but they just can't relate to you with how you are feeling."
(Female, 23 years, Broome)

"I reckon gossiping – gossiping has an impact on a young person's feelings which is their life. I think that especially if you are being spoken about or something as serious as sexual abuse and the whole town knows about it. People that you wouldn't think know about it. That could lead to suicidal tendencies." (Female, 25 years, Broome)

"Um, the general feeling it's a lot of blame shifting, um, rather than saying this is a problem or my child has a problem, there's a lot of – someone else's influence is making my child do this rather than recognising you know, that my child might be the cause of this or um, my child has a problem and I need to address it." (Female, 35 years, One Arm Point)

"I think they're probably not listening, they'll say when the thing is done, some of them will say, 'oh yeah we did not know what was happening, he can't tell us.' But there is times when young people are trying their best to talk to Elder in their family, the elder ones and they don't get no response, you know." (Male, 14 years, One Arm Point)

"I think by self-harming she's saying I need help. Like, I want people to feel sorry for me, you know, of what's happened. I am hurting. And maybe her perception at the time that nobody cared because they didn't show that care. So they act out to. Some people do it to get attention, but sometimes it's more than that. It's more to gain acknowledgement that they're hurting."

(Male, 43 years, Broome)

8.4 Risk Factors

Respondents were asked to describe the factors which they believed contributed to the development of social and emotional problems in Aboriginal children and youth living in remote communities.

Questions: *Some young people take a lot longer to get over a problem and may even get worse (like get depressed or have suicidal thoughts). What is it about these young people that they have a harder time getting over their problems? What about things in their family, community, culture, society?*

A variety of factors contributing to whether or not remote young Aboriginal people developed mental health and or social and emotional problems were identified. These ideas were grouped under two themes, namely risk and protective factors. Risk factors were those which were perceived to contribute to the development of problems in remote Aboriginal children and youth. Protective factors were those which were seen to reduce the likelihood of young people developing significant

problems. Risk and protective factors were found to be operating at the individual youth level, as well as in the family, community and society.

Table 11 presents a summary of risk factors at each level, which potentially influence the development of social and emotional/mental health problems in remote Aboriginal children and youth.

Table 11. *Risk Factors Which Can Increase the Development of Social and Emotional Problems in Remote Aboriginal Children and Youth*

Youth	**Family**	**Community**	**Society**
Alcohol & cannabis misuse	Alcohol & cannabis misuse	Lack of youth activities	Racism
Low self-esteem	Domestic violence	Lack of resources allocated to youth	Discrimination
School drop-out	Family fighting	Lack of cultural knowledge, practise	Negative stereotypes of Aboriginal people
Truancy	Too many children to manage	Few paid jobs	Lack of acceptance & understanding of Aboriginal people
Low educational attainment	Overcrowding	Lack of access to training	Culturally inappropriate services
Low intelligence	Isolated from extended family	Reduced socialisation outside extended family	Under-resourced services
Poor health & nutrition	Financial hardship	Fighting –disconnected community	Negative impact of colonisation:
Negative role in the family	Abuse & neglect	Lack of leadership, governance	Missions
Financial hardship	Harsh discipline	Lack of ways to manage problems	Welfare dependence
Multiple stressful life events	Lack of love, care, support, affection	Few local role models	Breakdown & loss of culture
Death of a loved one	Unsafe home	School – disconnected from community, transient staff	Being a minority group
Isolation from family, friends, community	Frequently moving house	Lack of relationship with outside agencies	Marginalisation from mainstream society
Pressure from family, friends	Adults use unhelpful coping strategies	Stigma about mental illness & agencies	Individualism
Poor social skills	Single parent family	No women’s & men’s groups	Materialism
Uses unhelpful coping strategies	Alcohol & cannabis use when pregnant	Lack of community identity & pride	
Difficult personality	Mental illness, suicide in family		
Unemployment	Teenage parent		
Lack of life, job skills	Lack of father figure		
Negative view of the future	Lack of responsibility for children		
No life goals	Lack of supervision		
Lack of responsibility for self & others	Family unemployment		
Living remote	Welfare dependence		
	Lack of cultural knowledge, practise		

There was no difference in Broome and One Arm Point responses pertaining to the main risk factors. The most common responses given by youth, parents, carers, Elders and service providers were: (1) lack of family and community support, (2) alcohol and cannabis misuse, and (3) family fighting resulting in a disconnected community. For example:

> *"You know, might be we are not listening to our young people, maybe not supporting them, with their education and family stuff, love and all that. Being there for them, they're not being listened to and to be a part of that. But maybe their families, and mothers and fathers caring for them, they too may be going through stresses and problems, and if they're not coping very well then how are they gonna manage to deal with their little ones"*
> (Female, 41 years, Broome)

> *"Trust your family and that family will look out for you – or you trust someone in that group, in the whole community, either an uncle or aunty, that gonna look after you, and support you all the way. If you don't have that trust and support, that's when young kids nowadays do alcohol and drugs and commit suicide."* (Male, 38 years, One Arm Point)

Youth reported that lack of family support (e.g., love, care, attention) was the main reason young people developed significant problems. Young people also cited boredom due to lack of organised activities and work, study or training opportunities available in the community. Lack of engagement in available work and education was seen by participants as a risk factor for problems such as alcohol and drug

misuse, peer pressure and vandalism. Young people interviewed believed that lack of support from adults and the community (e.g., Council) to run activities also contributed to problems. For example:

> *"nothing's changed you know, now no-one's looking out for the youth and they are the future of this community. They just need a little bit of help."*
> (Female, 18 years, One Arm Point)

One Arm Point Elders perceived that alcohol and cannabis misuse, lack of respect for self and others, few community-based activities and opportunities for young people, and the breakdown and loss of Aboriginal culture, were some of the main factors contributing to the development of youth and community problems. Other factors such as accommodation problems (e.g., overcrowding, unsafe homes, moving house a lot); racism and discrimination; and experiencing shame (intense shyness, lack of confidence), were seen by respondents to contribute to problems for young people. For example:

Accommodation

> *"Unsafe housing seems to be the basis for so many problems... When I say unsafe, I mean transient, as in moving from house to house, overcrowded house, or housing that the parents have – but there's this huge you know, whole lot of other people that are living in that house too. And I know from my own experiences that as a mother of teenage children there's one thing that teenagers like is their own space and their own privacy, and if young*

people don't have that, then they don't manage very well. Well all those sorts of things create problems of alcohol and substance abuse within the house. Too many people in the house, I mean you got people staying in the house that you don't know, you know there's always the issue of inappropriate sexual offences, if I could put it that way, but I mean I think there's always the fear of sexual abuse in there. Sleeplessness, tired, oh look I've seen lots and lots of tired kids because of the house involved, and when they're tired they can't think." (Female, 48 years, Broome)

Racism and Discrimination

"I think racism is still alive and very well. It can be such subtle, subtle things, done very subtly but it's still there and I think that contributes to breaking resilience. Especially for young people, they go get a job, there's really not much support for them when they starting in this job. It's like they have to work ten times more harder than other workers to get somewhere because of the fact that they are Aboriginal." (Female, 43 years, Broome)

Shame

"Oh shame that's the worst enemy I reckon – the devil in disguise [laughs]. I try and tell it to the pre-primary kids, 'now don't be shame, they aren't going to say anything.' You need someone to go out there and tell them. That's the shame, the one thing, the shame. I grew up with that shame from high school,

it was big shame. I don't know what behind it something there, that's the worst thing – shame." (Female, 34 years, Broome)

8.5 Protective Factors

Respondents were asked to describe the factors which reduced the development of mental health and social and emotional problems in Aboriginal children and youth living in remote communities.

Question: *Some young people face big problems yet get over them pretty quick and get on with life. What is it about these young people that they deal ok with problems? What about things in their family, community, culture, society?*

Question: *Overall, what do you think are the 3 most important things that relate to the way young people deal with problems and go on to live a happy life?*

Protective factors were identified at youth, family, community and societal levels, as summarised in Table 12.

Table 12. *Protective Factors Which Can Reduce the Development of Social and Emotional Problems in Remote Aboriginal Children and Youth*

Youth	**Family**	**Community**	**Society**
Belonging to family, peer group	Spend time together	Practise culture: language, Law, corroborees	Culturally aware
Education, knowledge	Strong extended family	Strong cultural identity	Show positive images of Aboriginality
Intelligence	Provide love, care, support, affection, acceptance	Land to belong to	Provide adequate resources, funding
Positive self-esteem	Clear rules & fair discipline	Safe community with enforced laws	Culturally appropriate programs & services
Strong identity	Teach & model good ways to solve problem	Provide work & training, youth & family activities	Agencies work together
Respect for self & others	Encourage education	Have youth safe place	Agencies deliver coordinated response
Uses helpful coping strategies	Engaged in work, study	Show strong leadership	Provide equal opportunities
Motivation	Respect one another	Functioning council, women's & men's groups	Inclusion in mainstream society
Optimism, hope	Provide a safe, stable home	Good relationship with school, wardens, clinic & outside agencies	
Does well at school, work, training, study	Take responsibility for family, community	Positive local role models	
Good health, nutrition	Do not misuse alcohol & drugs	Opportunities to meet outsiders	
Realistic goals	Practise culture	Come together in hard times	
Independence	Go fishing, hunting together	Value young people	
Self-responsibility	Do not fight each other or other families	Help youth seek support, opportunities outside the community	
Can function well in community/cultural & mainstream society	Manage finances	Strategies for managing problems e.g., fighting	
Got through hard times		School provides safety, support, culturally appropriate curriculum	
Stable accommodation		Clinic provides quality health care	
Easygoing nature			
Good social skills			
Leaves the community for work, study			
Not involved in fighting			
Does not misuse alcohol & drugs			
Good at something			
Can seek help from a trusted person			
Involved in activities: hunting, fishing, sport, music			
Religious/spiritual faith			

In terms of protective factors, Study 1 results showed no notable differences reported by youth, parents, carers, Elders, or service providers from either of the research sites. Participants reported that the most important factors protecting young people from developing social and emotional problems were: (1) support from parents or carers (e.g., love, care, affection, encouragement, acceptance, guidance), (2) support

from extended family and community, (3) spending quality time with family, (4) living in a connected community (e.g., families coming together as one group), (5) having community-based activities and opportunities for young people (e.g., organised sport and recreational activities, school or work, training and study such as TAFE operating in the community), (6) attending education, work or training, study, (7) positive self-esteem, and (8) knowledge and practise of culture. For example:

> *"I think the younger years are very important and to me it goes back to the thing about, if they have a strong family connection, when they become older and teenagers, in their 20s when they start, you know, that risk taking and drugs and experimenting. If they've got that sound backing of a strong family that loves them and supports them in loving way, then even though they do these things they'd be able to get through it and come back. If they don't have that strong nurturing upbringing then um, they may just keep going that self destructive path until something bad happens."* (Female, 42 years, Broome)

> *"Work has got to be the most important"* (Male, 36 years, One Arm Point)

> *"Um, whether they've got good family support. Whether they've got good communities – having a good community will provide good community support, and their own self-esteem, you know. Whether they value themselves as worthwhile."* (Male, 43 years, Broome)

> *"Having a good education, so they're confident to be able to speak to people on a par not think 'oh, gee, I hope they're not going to put out a form that I*

can't read' or you know, 'challenge me on things that I can't do'. So good education, supportive family and you know being confident in themselves."

(Male, 43 years, One Arm Point)

Parents, carers and Elders believed that having knowledge of culture, practising cultural activities and living according to cultural values was particularly important for young people, families and the community to provide a buffer against developing social and emotional problems. This included Elder leadership, belonging to tribal land, land ownership, speaking Aboriginal language, having respect and responsibility for self and others, coming together with other families for cultural activities (e.g., corroborees), sharing resources (e.g., food) with extended family, practising Law business, collectively looking after children and old people. This is exemplified below:

"Well culture is if they really put their minds into culture, culture would be the main positive, they'd be good. But culture used to keep us together because there was a lot of things that in culture, it was like a safe thing. You don't go wrong in culture life. And it was very strong in our time."

(Female, 65 years, One Arm Point)

"Well like going through the Law and everything like that, and it sort of makes them grow up and they can take on responsibilities later on in life."

(Male, 35 years, One Arm Point)

"Um – when they come back from their Law I think they had a new respect for the Elders" (Female, 49 years, One Arm Point)

"From what I can see, the kids that are on track have good support systems at home and they um, their parents are, you know, keep them active in, in um, I guess their cultural traditions you know, fishing, hunting and all that sort of stuff and um, spend time with their kids in a way. I guess the ones that I could see are good also have um, an outstation, so they're not actually just based in One Arm Point. They have somewhere that they feel they belong to, it's their little piece of, that they can retreat to, and they have ownership of it, they belong to something." (Female, 35 years, One Arm Point)

It is important to note that the factors listed in Tables 11 and 12 combine to influence the development of mental health and social and emotional problems in remote young Aboriginal people. For some youngsters there will be little impact of one factor or a combination of factors, whereas for another individual there may be a significant impact. In general, experiencing a range of risk and protective factors will result in either increased or decreased likelihood that problems will develop (Commonwealth Department of Health and Aged Care [CDHAC], 2000).

8.6 Defining Aboriginal Youth Wellbeing

Participants were asked to define a remote young Aboriginal person who did not have significant social and emotional problems or mental ill-health.

Question: *We hear this word wellbeing… How would you describe a young person who is going OK, happy in life?*

Some community participants did not commonly use the word *wellbeing* therefore the latter part of the question was used. In some interviews, the term *liyan* was used by the interviewers and interviewees instead of the word wellbeing. *Liyan* was a word more commonly used by some Aboriginal participants, particularly middle and older generations. The term *liyan* is used by Bardi people to describe one's feelings, spirit (Akilf, 1999).

The consensus amongst respondents from Broome and One Arm Point was that if a remote young Aboriginal person had good wellbeing/*liyan*, they would be doing well in their life; they would be physically and mentally healthy; emotionally happy; sociable (e.g., mixing with friends and family in a positive way); they would be engaged in work, study or training; the individual would not be fighting with friends or family; or be dependent on alcohol and drugs.

Some examples given by participants to describe Aboriginal youth wellbeing/*liyan* are summarised as follows:

- Doing something positive with their life – school, work
- Responsibility, independence (including financial independence)
- Looking after family – their own and extended family
- Socialising with peers, family
- Engaged in the community, with community people

- Engaged in positive activities, e.g., fishing
- Not fighting with peers, partner, family
- Sense of belonging to family, country
- Good physical health – looking after themselves, eating well
- Good mental health – clear thinking, not stressed

Many respondents defined youth wellbeing as a holistic concept, encompassing all aspects of the individual, such as mental, emotional, social, physical and cultural/spiritual aspects. Some participants viewed wellbeing as extending beyond the individual to incorporate family and community influences. For example:

> *"A sense of wellbeing for us, for me basically is spiritual. Energy, spirituality. You're at peace with yourself. You are physically looking good. You don't look run down or unhealthy. You're eating well…Socially, you know, you're talking to other people all the time. You know, you're not locking yourself away from everyone or always constantly hiding. You're um – physical, social, mental, spiritual…Mental in your mind. You can think clearly, you know, you're not flustered all the time when you're talking about things. You're not frustrated, you not angry all the time."*
>
> (Female, 32 years, One Arm Point)

> *"Wellbeing in Aboriginal people could be um, could be said that um – you have a place that you belong to, and you can go back there, you can leave it and go back, and you can still be accepted there, you know. Um wellbeing is about people coming together when there is problems and trying to sort it*

out, you know, people caring for each other. Wellbeing I think is about the person's own wellbeing, like health, like mental, physical, emotional and that part of things is looked after, is strong or nourished, you know."

(Female, 43 years, Broome)

Other examples:

"Doing the right thing for themselves, willing to come to school, motivated in all subject areas, chatty, sociable, helpful to others."

(Male, 30 years, One Arm Point)

"Probably a sense of self, a feeling of belonging, you know belonging either to a family or a community or even to a place." (Female, 48 years, Broome)

"Everything – the wellbeing of everything to do with the young person. Um, health, accommodation, everything. Doesn't mean everyone has to be perfect. A-ok. Stable accommodation, in school, support through school if needed. For example, tutoring. Also to have a good relationship with parents, be able to talk to them, being able to express your feelings without feeling like you're gonna be flogged. Be happy with your lifestyle, meaning living a good lifestyle in a positive way, know you are going somewhere, have direction, even if you don't succeed, have experiences in life."

(Female, 20 years, Broome)

8.7 Defining a Strong/Resilient Aboriginal Youth

Study 1 participants were asked to describe their views on what constituted a remote Aboriginal youth who had the ability to come through adversity and live a positive and productive life.

Question: *Some young people overcome a lot of problems and get on with their life. What do you think makes young people this way? How would you know they are a strong person?*

All Aboriginal participants agreed the word *strong* was suitable to describe a young person who was able to overcome significant problems and lead a good life. Most non-Aboriginal respondents preferred to use the word *resilient*, although they still related to the word strong as a word commonly used by Aboriginal people in the area. This question also elicited strengths in young people and therefore has some overlap with the question on protective factors.

Participants described a strong or resilient Aboriginal youth as someone who:

- Has the ability to deal with problems, get over hard times
- Can cope well with negative emotions (e.g., anger)
- Is doing well in either education, training, study, employment
- Is engaged in sporting, recreational, cultural activities
- Has respect, responsibility for self and others
- Is a role model, helps others

- Is able to seek help, ask for advice
- Is motivated, willing to give things a go
- Does not drink alcohol or use cannabis excessively
- Is happy, able to have fun
- Has a strong connection to family and or peer group
- Has cultural knowledge and practises culture
- Has positive self-esteem, confidence
- Good social skills (e.g., able to talk to people outside community)
- Manages money (e.g., has a car, pays rent)
- Is independent, doesn't succumb to negative peer influences
- Can navigate in community/cultural and mainstream life
- Has goals, future aspirations

For example:

> *"They would be a role model sort of person who is doing the right thing, they would be happy in life, have a good group of mates. They would have good self-esteem and be motivated. They would be involved in the community."* (Male, 30 years, One Arm Point)

> *"I guess for me people who are strong are people who have a good strong family…they're taking care of their own family you know. They're still with their partner or they've still got their kids…I guess they're involved in the community in some way, or even just you know, they're happy and their kids are happy."* (Male, 59 years, Broome)

"They seem to be committed to some direction, as far as work or education. You know, they are the ones who seem to stay at school a bit longer, the ones who seem to get jobs even if they are part-time, you know, like casual jobs. They just seem to have you know, a better ability to handle themselves, manage their lives a bit better. They seem focused, that's what it is, they're focused a bit more." (Female, 48 years, Broome)

"They would have good self-esteem and wouldn't be afraid to talk about the good things they've done. Um, they would be in a position to love and be loved I think. They would be in a position to um, take the knock backs that life dishes out without having to go and get blind or get angry, or go belt someone or be belted. Um, they would be able to say to themselves and other people – 'well that's all right I'll do better next time.' Be able to smile and laugh and still be in a position to listen and support other people who are in distress as well." (Male, 34 years, Broome)

Some participants pointed out that being strong or resilient can also become a risk factor whereby competent young Aboriginal people can be overburdened with responsibility for peers and or family, or feel immense pressure from their families and communities to succeed.

The following section provides a synthesis of the findings from Study 1. Quotes from Study 2 and 3 have been added where participants elaborated on youth and community problems discussed in Study 1.

8.8 Conceptualisation of Problems, Risk and Impact

8.8.1 Breakdown of Culture

One Arm Point was viewed as having a relatively strong culture, however many participants reported that the breakdown and loss of their culture was a significant problem and contributing risk factor for other social and emotional issues affecting youth and community wellbeing. Bardi Elders reflected that problems such as alcohol and drug misuse, prolonged fighting, suicide and sexual abuse were unheard of in their youth, for example:

> *"Suicide, that's got really worse and - like I was saying going back to my generation time they never knew anything about suicide, never heard of it."* (Male, 55 years, One Arm Point)

The community had experienced a marked increase in these and other problems over the last 20 years. Older community participants remembered that their culture was strong when growing up on Sunday Island. Elders were respected by all and upheld the Law which governed everyday life. Everyone knew right from wrong. There were accepted ways of managing problems such as disputes, so issues were resolved without affecting the unity of the group. Family structure and ties were strong, making a cohesive and connected tribe. Respondents noted that the extended family took responsibility for raising children and young people received lots of attention and guidance from their Elders. The old people were well looked after by all families, who shared food and other resources amongst the whole group. Families participated freely in joint meetings and gatherings. Corroborees were held often,

solidifying family and cultural connections. Everyone spoke their language. For example:

> *"Yeah there was, we were the ones that used to walk from one end of the island with a lot of turtle meat or fish that we caught a big catch and take it to the old people and share it with others…Somebody got a dugong today, he'll cut it up and they'll put it in his freezer today. But in those days dugong been shared right through the island, right through the whole camp."*
> (One Arm Point feedback group)

Participants reported an initial breakdown in cultural values and practices, as well as fragmentation of social structure with the onset of missions. The Bardi people were able to stay together on Sunday Island Mission and practise some of their culture, however their lifestyle changed with the influence of Western beliefs, religion and missionaries managing their lives. Other participants reported that in some missions on the Peninsula, they lived separately from their parents and were not allowed to speak their language or practise their culture. Many lost their families, culture and language, although some reclaimed this later. For example:

> *"Nobody was allowed to speak their language, it was a big thing. You know – old people are saying kids not speaking their language anymore and who's fault is that, that's the White man's fault cos they say you can't speak that language at school, you can't speak that language in public, they was against that."* (Female, 32 years, One Arm Point)

A continued breakdown of culture and family structure was noted during the period from closure of the mission settlement at Sunday Island and relocation of families to Derby. Participants reported that families lived more separately, less culture was practised and taught and some people became afflicted with alcohol. Bardi Elders moved their families to One Arm Point to rekindle family and cultural connections. The establishment of One Arm Point Community was remembered as a time of unity and renewed hope, where people worked hard to build the community. However, participants reported that following this time, problems progressively got worse for the community. This was attributed to many influences. For example, traditional methods of leadership and governance were replaced by the community council/administration system. According to participants Elders were still viewed as leaders but lost the means to lead. People had difficulty with self-government, and making and enforcing community by-laws proved a huge challenge. Respondents highlighted that Elders' power to assert leadership and control diminished. The community faced major governance and management issues, including difficulty managing community problems, such as violence, drug and alcohol abuse. For example:

> *Yeah, when I was a child we were starting out One Arm Point Community, we made some strong rules, unfortunately these rules were regularly broken down by individual family groups you know. Well these days nothing is dealt with full stop. Not differently, just not at all full stop... it's a gradual build-up where I s'pose we as the governing body at that time, as the Council, didn't take tough measures back then and you know the governing body itself breaking down…We, as the governing body just let it deteriorate to the*

current mess it is today, we just didn't take tough measures, take tough rules, ban them…" (Male, 36 years, One Arm Point)

Participants reported that other influences, such as alcohol, drugs, fighting and gambling seriously impacted on people's ability and motivation to teach and practise culture. Some old people had become dependent on alcohol and were reportedly too drunk to organise cultural teaching. Some young people were more occupied with drinking, drugs and DVDs than learning their culture. Elders had lost respect for youth and believed some were not worthy enough to learn culture as they would not respect it. Young people had lost faith in their leaders and no longer approached them to learn culture. Culture was not being taught to all children, only those fortunate enough to have relatives with the knowledge and impetus to do so. The community was losing many treasured old people who died before they had time to pass on their cultural knowledge. For example:

"You know, you hear of it everywhere that people are trying to you know, rebuild it (culture) and getting it up and going again but… I don't know if kids these days have that same interest. You know there are some people out there that - want it, you know, get it back, that believe very strongly - but then there's others who just don't give a shit, they don't care about that kind of stuff. They're more worried about drugs or they're more, they'd rather have a drink or, yeah, they got video games or you know, they've got all these other things that can occupy them, you know, that it's not, it's not a major priority in their life." (Female, 22 years, Broome)

The gap between the old and young people had widened with less understanding of each other's ways. Participants noted that many young people were forging their identities on American (e.g., rap music) rather than more localised cultural ideals or those in mainstream Australian society from which they were also isolated. Participants reported that youth struggled to deal with two cultures and form a positive self identity. The generational and cultural divide amongst the young and old had negative consequences for both. Youth were more marginalised with fewer people to support them. Elders felt they had lost their powerbase and thus control over young people and the community. Hence, they believed they could not fulfil their role of teaching and guiding young people. For example:

> *"Well there's no more connection with the younger and the Elders, people just sort of walk away from us, you know. They don't respect Elders anymore...No it's gone. It's gone. Respect has gone and it's something that's really important in the community, for all of everybody, you know. I mean, especially for people like us, you know, tribal people. There was a lot of respect in the early days and that's something we haven't got today."*
>
> (Male, 71 years, One Arm Point)

The breakdown of family structure had negative outcomes for young people and the community. Families had become increasingly separate from one another. They were more likely to pursue their own interests (particularly economic) rather than focus on collective pursuits, a result of Western influences of individualism and materialism. Many children were now cared for by immediate family or a sole caregiver (e.g., grandparent) rather than the group, which meant the community was less likely as a

whole to take responsibility for the welfare of children and youth. As a result, young people received less support. Respondents reported that young people received less guidance and discipline from those who had usually been accepted parenting models (e.g., auntie, Elder). Families spent less time coming together as a group sharing cultural and social activities, further perpetuating the disconnection amongst families and breakdown of cultural and social structure. For example:

> *"And that's the danger it's kids who've got strong families and strong parents have strong culture. The kids who have the family structures broken down aren't getting that culture. So they're losing family and they're losing culture. They're losing it."* (One Arm Point feedback group)

8.8.2 Alcohol and Drug Misuse

Participants viewed alcohol (grog) and drug (e.g., gunja, marijuana or cannabis) misuse as a major problem impacting on young people, families and the community, as well as one of the main risk factors for other problems, such as family fighting and domestic violence, suicide, abuse and neglect, financial hardship, unemployment, school difficulties and breakdown of culture. Alcohol and drug misuse was reported to be community-wide. Children experimented with alcohol and drugs from a young age and more than half of youth reportedly used cannabis. Participants stated that alcohol and drug misuse had progressively got worse in the community. For example:

> *"Well, I've heard rumours 'round here that we've had kids as young as 10,13 basically smoking marijuana and carrying on…Oh, it's just been getting*

worse and worse. It's been happening for the last 5 to 6 years yeah, you know, just getting worse and worse. Our kids are actually turning to drugs instead of doing anything else." (Male, 36 years, One Arm Point)

Participants gave several reasons for youth engaging in substance misuse. Many young people had grown up with their relatives using grog and gunja, thus this behaviour was normalised for them from a young age. Several participants stated that family members or peers pressured young people to drink or smoke and youth found it difficult to resist such pressure. Young people unsupervised by adults and those not engaged in school, study or work were more likely to misuse substances. Participants believed that alcohol and drug misuse was symptomatic of other problems. They reported that alcohol and or drugs were widely used by community people to deal with their problems. Many families and young people had experienced multiple traumas and loss, such as death of loved ones, suicides, abuse and neglect. Young people reportedly used alcohol and cannabis to numb negative emotions, to alleviate distress and tension, particularly related to trauma and loss. Many youth had no jobs, had dropped out of school and experienced hopelessness about the future. They also experimented and misused substances for "something to do", to relieve boredom and feel good. For example:

"Sure for some people it will lead on to major mental health disorders but the majority I think it is a symptom under their distress. It's their own way of sort of self-medicating to just black out a little while, and to just switch off and escape, um just reality." (Male, 34 years, Broome)

"No goal ahead of them, that's why they think, 'I have nothing,' and smoke".
(Male, 17 years, One Arm Point)

"The only thing we've got to offer you know is, have a look around – drunken people, fighting people, kids dirty, no health, no jobs, nothing. That's not a lot to offer them. Kids see that. 'Oh bugger it, I'll go get a can.' There's no hope, no light at the end of the tunnel for them." (Male, 43 years, Broome)

Other reasons given for drug and alcohol misuse were lack of governance and policing in the community in relation to the supply and use of substances. Some people were reported to be prospering from bringing drugs and alcohol into the community and illegally dealing cannabis to community members. For example:

"As I said it's getting worser and worser and um, marijuana is more accessible, alcohol is more accessible. Over the years you know, the last few years we never had vehicles going in and out of town, nobody knew about marijuana 15 years ago, now it's accessible, because of that people are buying flashy cars, they are benefiting directly from dealing and wheeling in marijuana and they're the ones that supplies the community, and with that they get vehicle and they get more access to come in and out of town and come back on a regular basis and the more alcohol and the more marijuana, the worse it's going to get, 'til we put a stop to it somehow."
(Male, 36 years, One Arm Point)

The impact of alcohol and drug misuse was reportedly debilitating and widespread. Many respondents believed substance abuse particularly alcohol, was the main contributing factor to fighting amongst families, and parental domestic violence. Young people reported their concern about drinking and drug misuse amongst family members. Children and the elderly were victims of drinking and subsequent violence occurring in the home, where living situations became overcrowded, unsafe and chaotic. Children were left unsupervised, thus some were thought to be vulnerable to sexual abuse. Young people were also impacted by familial drinking and drug dependence where money was spent on substances and gambling rather than food. Children's education suffered as a result of drinking and fighting in the household where some would not turn up for school or come to school hungry and tired. Older people were reportedly "humbugged" (bothered) by family members, including youth, for money to buy alcohol and cannabis. For example:

> *"There's never any money. Um because mum and dad have spent it on pay day. They're living on book ups at the shop, it all goes on gunja. I mean a carton of grog here is about $80. They have $50 for casks of wine."*
>
> (Female, 47 years, One Arm Point)

Participants reported that dependence on alcohol and drugs resulted in lack of motivation to attend school, work or training, lack of interest to participate in cultural or recreational activities, lack of direction, apathy, hopelessness and helplessness in young people. For example:

"We talked about taking them out, to dance, taking them long way and taking them out, tell 'em stories about the Law and just try and get, and a lot of them kids are interested in the Law and learning it, to a certain extent and then, along comes the alcohol, gunja. Sort of sidetracked them and this is what's happening, you know." (Male, 49 years, One Arm Point)

"Um, it (gunja) has a big impact. I see a young generation don't wanna do anything for a start. Actually makes our young kids lazy I suppose. It makes them agro to a certain extent, they don't want to commit themselves, they don't want to go any further, they just want to stay home and smoke or drink, watch TV and video all day. They don't even want to go down to the beach or go fishing, they just like to sit down all day, become very lazy and non-active." (Male, 36 years, One Arm Point)

Alcohol and drug misuse, particularly alcohol intoxication was seen as a very unhelpful way to manage problems, precipitating suicidal behaviour and self-harm and exacerbating mental health problems such as depression. A small number of young men reportedly experienced drug-induced psychosis, delusions and schizophrenia related to long-term cannabis abuse. For example:

"We see lots of kids in this community who started gunja very young, and then by the time they are 19 or 20 they're already getting some changes mentally. In fact we've got two boys in this community under the age of 40 who are both schizophrenics as a result of long-term gunja use."
(Female, 47 years, One Arm Point)

8.8.3 Family Fighting

Family fighting (also called feuding, family violence) included domestic violence amongst parents/carers, fighting within and between family groups, as well as fighting and bullying amongst young people. Fighting included physical violence, disputes, threats, jealousy, and "put-downs" (criticism). Young adults were reportedly most active in family fighting, although all ages could become involved, including the elderly and young people. Participants reported that fighting usually started amongst a few people then the whole family group would get involved. Fighting could extend from families in the community to families in Broome and visa versa. Men were reportedly involved in more physical fights than women although this had evened out more recently. For example:

> *"Young girl goes home with a problem, tells her mother, then all the sisters, and all the cousins, and all the aunties, all want to get involved. The uncles too they'll want to get involved. How can anybody like men go out and openly fight some other family's young girl, you know. Then that's when the menfolk on that side get involved. It's just a never ending crazy thing that happens, and nothing good comes out of it. That's the worst part of all. Nothing good comes out of it cos they're all walking 'round bearing grudges. There are some people who are involved in these arguments who are very sick. They don't know whether they're gonna still be on this earth next year or not, or in a couple of months time. And they be well respected by other people, they have to, when they leave this world there's no reconciliation between these families."* (Female, 55 years, One Arm Point)

> *"Oh, well, whatever happens in town, drunken brawls, you know, that happens in town it comes back out here you know. That's with alcohol and this and that you know and oh, family feuds. It's just, whatever happens in town you know, just brings it back to the community and just carries on for days, months on end, you know."* (Female, 23 years, One Arm Point)

The older community participants reflected that fighting amongst families and domestic violence had increased over the last 20 years. Hostilities reportedly originated when families were moved from Sunday Island to Derby and later established themselves at One Arm Point. Participants gave varying accounts of the origins of family conflict amongst community-based families, including unresolved disputes about "rights" to culture (e.g., dances, stories); jealousy about financial gain; disputes about money; anger and resentment due to feelings of hopelessness directed toward others. Some reports suggested that anger about sexual abuse of young people was an underlying factor in fighting amongst some family groups. For example:

> *"They don't like anyone succeeding. They like to have everyone at their level kind of thing…That, they are very jealous of a family that gets ahead. Um – then they will taunt them and ask for loans or you know, say like 'big shot, who do you think you are?"* (Female, 49 years, One Arm Point)

Participants believed that many children were exposed to family violence, either fighting amongst relatives or domestic violence, thus the use of verbal and physical aggression was normalised for youngsters from early childhood. Children experienced their parents speaking negatively about other families and this fuelled

hostility in young people toward other family groups. It was reported that fighting to solve problems was encouraged by some families, such that if you didn't fight you were perceived as weak.

Some examples:

> *"The parents, the kids see their parents fighting, that's a problem for them. You know too when they go out and ending up the same way."*
> (Male, 38 years, One Arm Point)

> *"I mean, the very people here I find very jealous and they take their hate on, it's passed down from the adults to the kids and it's still, from what we've seen, they like to carry the fight on. Instead of just saying, 'come on draw the line and close it off'. So I think probably some of the younger generation is getting the hate from the family thing down. They fight for their parents. The women will fight for their mothers because the mother might have a heart problem."* (Female, 49 years, One Arm Point)

> *"is the belief amongst our people/youth is that fighting is the way to solve problem and it's encouraged by many families. Most believe that if you don't fight, you are gutless. No-one understands that it can be sorted differently without fighting. This leads to big family fights."*
> (Written feedback Broome youth)

All participants perceived alcohol misuse and or intoxication as the main precursor to family violence. Family members often sought to solve disputes when drunk. Young people's dependence on cannabis was also viewed as a contributing factor to fighting with relatives, when young people demanded money to buy gunja, this would often erupt into an argument or physical altercation. For example:

> *"Could be the person they got a problem with or could be the person related to the person that they got a problem with, it's mere fact that it's alcohol is just – it brings out the anger in them I s'pose it brings out all the stuff they've got hidden in them and like a loose cannon comes out when they've got alcohol. And after that when they do bring it out and get it out and they sort their trouble out, or have a fight or whatever it goes back in again, you know, the problem is still in them but they don't sort it out. Just makes it bigger and then they go back to their shell and next time they get alcohol again they bring out the problem again, so yeah, it's like a never ending process. I mean you got a lot of fights happening here that should've been sorted out years ago, but still it's being dragged on. Even the kids, little kids are starting to speak like their parents now, you know. It's scary and sad I can tell ya."* (Male, 29 years, One Arm Point)

Participants conceded that family fighting and violence continued to occur as there was no effective management of the problem. Old disputes often resurfaced because they remained unresolved. Older participants attributed this to the breakdown of culture, specifically the loss of traditional structures (e.g., Elder authority and Law) and methods for managing disputes. Participants also reported, that more recently,

Council and wardens were delegated the role of managing and mediating fighting amongst individuals and families. They have found this difficult without adequate policing based in the community, lack of support from the community, and family members finding it hard to remain impartial in the conflict. For example:

> *"What mum just said, there on Sunday Island when people fought they had boomerang fight, they had blood streaming down, especially men, womans were there. They walked down to their men's ground, sat together in groups, they sat together, sat down and talked. That was to sort the problem out and it got sorted out. No-one complained about it. That was it, that was over. Not feuding for months on end and different family groups keep on going, keep going like that."* (Female, 63 years, One Arm Point)

> *"There is no law, there is no justice, and people live here to escape from the real world. Like I can't live like this in Broome. But if I'm an Aboriginal and I live at One Arm Point I can do whatever I like. I can break the law, I can bash whoever I like, and there's not one person who can stop me. You know, police don't come in, poor old wardens get abused, and you can really do as you like."* (Female, 47 years, One Arm Point)

Family fighting was seen to have a devastating impact on young people. Youth living with violence in the home and community indicated that they felt unsafe, anxious/fearful, isolated, unsupported, depressed, helpless and hopeless. Some children and youth reportedly presented to the clinic with somatic complaints (e.g., stomach upsets, headaches) as a result of experiencing violence. Some young people

conveyed that they would prefer to live elsewhere as they felt unsafe in the community. When family fighting was occurring youth were afraid to visit Broome as they feared attacks from rival family groups. Participants acknowledged that young people had few skills to manage their distress related to feuding and violence. Youth reportedly had few helpful ways of dealing with conflict, other than fighting.

Parents and service providers commented that fighting and ongoing feuding impacted on young people attending school, work or other activities. Children from disputing families were more likely to be involved in or be the victims of bullying, excessive teasing, threats and fighting at school. Children as young as pre-school age whose relatives were involved in feuding avoided children from rival families. This resulted in segregation and alienation in the school context. Some children were removed from school or did not attend school during periods of feuding and fighting for fear of victimisation at school. Young people also faced verbal attacks at work. Family fighting was seen to have a significant impact on educational attainment and stability at school or work. Some examples:

> *"It is a major problem, again it's a community-wide problem with big family groups are fighting amongst themselves, the kids are going to school and certain kids are picking on this kid so visa versa cos their families are disputing."* (Male, 36 years, One Arm Point)

> *"Well you ought to see my grandson here. As soon as he go to school, he get picked on. So he don't go school no more. We ask him to go to school but he won't, he'll say, 'No, they'll tease me'."* (One Arm Point feedback group)

"And I remember when all these fights were going on, you know, a couple of Elders that I'd spoken – speaking to, send their kids away at that time, or you know, they don't bring them to school because of that interaction in the classroom. Cos it can flare up in the classroom, 'Nah, you said that!' 'Your dad or your uncle or whatever said that!' You know, so they ship 'em off to Perth again or where ever or you know, just keep them out at their outstations and say, 'Nup, look when it settles down in a couple of weeks he'll be back at school, or she'll be back at school.' So yeah, it really does affect their education." (Male, 31 years, One Arm Point)

"I work at the store and the opposite family member sort of come in, because I'm a family member of that family that fighting with them, they sort of like go at you, that family of that family, and sort of you know involve the person that approaches, just thing like that, see. I try not to let it get to me, it's really hard." (Female, 23 years, One Arm Point)

Participants reported that fighting and continued hostility and tension amongst families was hugely detrimental for young people, families and the community. Family fighting had contributed to the breakdown of both immediate and extended family structure, resulting in disconnection and segregation amongst family groups. On the whole, families were operating in their own groups. Less time was spent together communicating and caring for each other, sharing activities, thus support for one another had diminished. Children, particularly those with inadequate parental support were thought to be most vulnerable, as they had less people overall "looking

out for them". Some families had moved away from the community to their outstations to avoid fighting and hostility. Cohesion amongst Elders had also disintegrated, resulting in fewer cultural activities being taught and shared amongst the whole community. Fighting and feuding had disrupted the unity of men's and women's groups, council meetings, and youth and family activities, making it difficult for the community to come together, share in activities, and run the community, particularly to deal with community problems. For example:

> *"Um, to start off we get, we get a lot of fights around here, you know. All family fights. And when you don't have the community members all linked together, mixed together, you tend to split apart in the community."*
> (Male, 21 years, One Arm Point)

> *"It's just, this place is not really a place for um young people – and, with the fights like, it's terrible, when the fighting happens everybody gets to the state where nobody wants to talk to no-one and it's like, it's a zombie, turns out to be one big zombie place."* (Female, 23 years, One Arm Point)

> *"I think it's important for the whole community, the whole community to come together and be one, you know. At the moment now, we all pushed to one side, this family pushed to one side, and people walk around here with bad liyan. They walk around here knowing that they fighting and say, 'I don't like him' and 'I don't like them', you know."*
> (Male, 38 years, One Arm Point)

8.8.4 Lack of Youth Activities and Opportunities

A common problem reported by all participants was that young people living in remote communities had "nothing to do". There were few organised youth activities, as well as lack of paid work, training and study based in the community. The majority of paid jobs were filled by non-Aboriginal staff. It was reported that Community Development Employment Projects (CDEP) was one of the few vocational options available to youth and this system was poorly managed and provided little incentive for people to work for the government money they received. Many young people did not attend school regularly and or dropped out of school early, without obtaining adequate reading and writing skills. For example:

> *"You kinda get no opportunities in this community. Everything's gone to waste, even the Council has gone to waste [laughs]. It's true, I've seen it. Well for instance, TAFE. You don't get much TAFE. They gotta travel all the way, and they expect us to travel into town for that, you know. Also, sports and rec' and all that, you know. Like you get a lot of people with good talents at sport but they don't want to show it because there's nothing to show, you know. No-one's encouraging them to play sports, you know. Only sport here's basketball, that's the main thing, you got an oval there, sitting there that's all getting into bush and all that. No footy and that's what they really like - footy. That's what we, tipping and everything, you know. But there's no oval to kick on.."* (Male, 21 years, One Arm Point)

> *"there's not much here in this community, we haven't got much to offer to the community mob, so they might go somewhere else. We don't have enough*

here to um basically, we don't have enough opportunity for the young kids to go on to employment, get a decent job, cos the community is not in that financial situation." (Male, 36 years, One Arm Point)

Participants reported that some young people lacked family support to attend school. Youth had little support from family and the community to organise activities, pursue work and training outside the community, and few skills to attempt this themselves. For those youth who did leave the community to undertake schooling, work or study, they were often ill-equipped to deal with the challenges of living away from their families, such as managing finances, finding a job or accommodation. Subsequently, many would drop out and come back to the community. Participants reported that many community-based young people followed their parents' path to unemployment and reliance on welfare. For example:

"As for myself I can say that, for the young people around here there really is no support in things for them like, things in so much in ways that nobody is really helping, getting out there helping them and actually setting up things for them as in projects, or as in drop-in centre or anything like that. They finish school and there's just nothing there for them, you know after school or even at night, they always seem to be hanging 'round school at night."
(Male, 29 years, One Arm Point)

"Yeah not getting the support they want. It's like I'll help you but in a couple of weeks or months, nothing's been done."
(Female, 18 years, One Arm Point)

The lack of activities and lack of engagement in structured activities, such as school, study, paid work or CDEP impacted significantly on young people. Participants most commonly reported that young people experienced boredom. Under-achievement at school and unemployment reportedly resulted in low self-esteem and confidence and poor educational, vocational and life skills. Participants also commented that the lack of engagement in community-based activities reduced the opportunity for children and youth to socialise and learn pro-social skills. Without adequate skills and often awareness as to how to attain opportunities outside the community, youth were thought to be marginalised from opportunities outside the community and mainstream society in general. Most young women who had dropped out of school went on to early pregnancy, with inadequate skills to cope with the challenges of parenting and relationships. With few long-term job prospects to look forward to, youth lacked motivation, future direction and goals. Some children and youth not engaged in school or other structured activities were reportedly involved in juvenile crime (e.g., vandalism, stealing). Both young men and women disengaged from school or work were perceived to be more likely to drink alcohol and smoke cannabis, and were more susceptible to peer pressure and fighting. Many young people experienced hopelessness and had a negative view of their future. They reportedly turned to cannabis and alcohol to cope which exacerbated and complicated these symptoms due to drug dependence. For example:

> *"Oh, the boys they – the young boys now starting to break-in and, break-ins. They used to break into the store and school, even the day-care. Um, yeah, stealing. They used to go and ring the bell at the clinic, mainly in the early hours of the morning, 1, 2o'clock in the morning."*

(Female, 18 years, One Arm Point)

8.8.5 Suicidal Behaviour

Many young people and families involved in this study reported they had lost immediate or extended family members to suicide. Some had experienced suicidal behaviour in young people and some youth reported past suicidal ideation or attempts.

Participants cited many risk factors for suicide. Of those who did discuss suicidal behaviour, most believed that rejection and subsequent isolation from family members was a common contributing factor in suicide. Participants reported that fights with family or partners precipitated some suicidal behaviour. For those young adults with children, not being able to see their children due to relationship conflict and separation also contributed to considerable distress and suicidal behaviour. Those known to have suicided had experienced one or more of the following: substance abuse or intoxication; childhood histories of abuse (e.g., emotional, physical, sexual) and or neglect and the trauma associated with this; guilt and shame related to sibling's experience of sexual abuse; sexual identity issues mostly related to childhood sexual abuse; death of a parent, carer or close relative, including death from suicide contributing to profound grief and loss; depression, hopelessness. For example:

> *"So then that's when the boyfriend wants to go and do something and the girlfriend's like, 'No you can stay here and help me look after this child.' He's like, 'No way, I'm hanging out with the boys.' Then the arguments start*

and the fights, and then they break up and the mum takes the child away from the father and the father's like, 'Well if you don't bring him back I'm going to kill myself and if you don't come back to me I'm going to hang myself,' and all those kinds of things. Cos that's what happened a lot of the time."
(Female, 23 years, Broome)

"My sense is up here the young people in the Dampier Peninsula and Bidyadanga would be able to name two or three people who are either immediately related or considered very close to them, who have taken their own life. Sometimes we as service providers underestimate the effect on a young person. Yes, I think that that is a huge thing, and then because it's foremost in their mind it becomes one on the list of 'how do I cope with a traumatic event or stress', and becomes one of the things that they readily consider." (Male, 34 years, Broome)

Participants reported that the way family, community and agencies responded to signs of distress strongly influenced suicidal behaviour. Where family members ostracised, punished, blamed, ridiculed, or ignored the person displaying suicidal behaviour (e.g., attempting suicide, talking about suicide), this increased the risk for suicide either at the time or later, due to lack of supported resolution for the person's distress, which increased feelings of rejection, isolation and helplessness. Some participants believed that the lack of resources in the community to assist people experiencing problems, either in the short-term (e.g., crisis intervention) or longer term (e.g., counselling) contributed to prolonged distress and suicidal behaviour. Individuals who had no alternate strategies to manage distress, no perceived supports

in the family, community or outside the community, and who felt too ashamed to seek help were thought to be more at risk of suicidal behaviour. For example:

> *"But when they feel left out, when they do that and no-one will take notice you know. Some of them do it and especially the young men like um if they need to talk to someone about say if they've been abused or that, they don't know who to trust and they try to hurt themselves but they also probably get in trouble because they think all the family, some of them will think oh, 'what you do there, what you try and seek attention for'. But they don't realise there is underlying issues you know, in some of them that do that."*
> (Female, 44 years, Broome)

> *"when somebody was getting very depressed, talking about you know (suicide), and the others in the family were saying, 'well go and do it, I'll tie the rope up for you, we'll help you hang the rope up to the tree, or pull the trigger'. Not like you know nobody would say he looks sort of troubled and he's going through a bad time, you know maybe we should take him somewhere, he needs to speak to someone, nothing like that. Always negative like, 'you're being a sook, you know get over it, pull yourself together."*
> (Female, 41 years, Broome)

> *"I just get the sense that they don't…the young Aboriginal people of the West Kimberley don't feel at this point in their life that they have an option even to go out and source out help they need…There are some agencies out there,*

but if you're living 200 kms away and an incident happens on a Friday night, the number of agencies are pretty limited, actually to give help."

(Male, 34 years, Broome)

The unhelpful coping strategies perceived to contribute to suicidal behaviour operating at the individual, family, community and outside agency levels are summarised in Table 13.

Table 13. *Unhelpful Coping: Suicidal Behaviour*

Youth	**Family/Friends**	**Community**	**Outside Agencies**
Using alcohol & cannabis Feels too "shame" to seek help Lack of trust in others & agencies Does not know where or how to seek help Sees no alternative Fights with others Isolates self - "takes off" Blames self	React punitively to youth seeking help Ignore, isolate, reject Give youth alcohol or drugs Try to solve problem when drunk Not sure of signs & symptoms to look out for	Isolate, blame young person, family No mental health service based in the community Lack of training to deal with problem	Few resources to provide support & counselling in the community Lack of training Uncoordinated agency response No follow-up Lack of consultation

The impact of deaths from suicide and suicidal behaviour (e.g., attempts) was devastating to young people, families and the community. Some young people who had attempted suicide or witnessed suicidal behaviour in family members reported ongoing trauma symptoms (e.g., flashbacks, avoidance). Participants reported that the experience of trauma, grief and loss in family members from deaths related to suicide had contributed to anger, depression and substance abuse. These symptoms had been so overwhelming for some young people that they had considered suicide, seeing no other way out of their distress. For example:

"when they did it, you know, the suicide, they kind of put an influence into us mob, you know. That's the only thing you think about. Like for me I think about that when I'm depressed, you know. Think about leaving, but I don't wanna do that, you know, because I wanna live long and like you know, get on with life." (Male, 21 years, One Arm Point)

8.9 Conceptualisation of Strengths

Those young people perceived by participants to be doing well in their lives had the love and support of their families, including extended family members. They were brought up in families where culture was taught and practised by strong Elders, they learned the values of sharing and respect for self and others. Family members did not drink alcohol excessively or misuse substances, and they modelled positive ways of managing conflict. For example:

"The whole family has respect from an early age. I know that was one thing that get us through… That's the reason why you see us all together, you know. There's hardly any fights amongst us you know, among my kids."
(Female, 36 years, One Arm Point)

These young people spent time with their families engaging in cultural activities (e.g., hunting, fishing) on the land they were traditionally from (e.g., outstations), learning about and reinforcing their connection to family and country, fostering a sense of belonging, pride and identity. Families were also open to spending time with related families. This provided more sources of support for the young person (e.g.,

uncles, aunties, cousins/peers). Participants reported that keeping young people occupied and interested in cultural, family and recreational activities deterred them from drugs, alcohol, fighting and feeling bored or isolated. For example:

> *"I think it's, they have a strong extended family so it's not just mum and dad, but there's aunties, uncles, cousins, brothers, they all sort of have that role, they all, it's not left to just one person to do it, everyone does it, everyone looks out for them and everyone keeps them in check."*
> (Female, 35 years, One Arm Point)

> *"Oh, I guess good family ties, um I guess cultural values like living on your land or being close to your land and being close where your family is from and being close to your family. Even just going fishing on the weekend, taking your kids fishing um these sorts of things. Activities that keep you occupied so that you can't be or you don't have so much time on your hands that you've got nothing to do and you can easily go off and go with your mates and get on and charge and that sort of stuff."*
> (Male, 25 years, Broome)

Youth who were considered to be doing well were engaged in school or work in or outside the community. They were given encouragement, support and guidance by parents or extended family. They had relatives who were positive role models (e.g., engaged in work or study). A secure and nurturing family system fostered self-esteem in youngsters which gave them the belief that they could give things a go. Respondents noted that strong young people were not immune from experiencing

problems, such as breakdown in parental relationships, death of loved ones, bullying, community fighting or abuse. Some of these youth had spent time consuming substances and a small few had contemplated suicide when they felt isolated and found it too difficult to cope with overwhelming distress. However, someone in their family was thought to have been looking out for them. They received help from family, often grandparents, which usually consisted of listening, encouragement, guidance and providing a safe place for the young person to go. This built their trust that they would continue to receive support, encouragement and nurturance from their family, and strengthened their self-worth and ability to get through hard times without relying on alcohol, drugs or violence. Resilient young people went on to seek opportunities, such as work (usually CDEP) in the community or neighbouring communities. Through sticking at work or training, young people were able to build their skills and confidence, some venturing on to paid jobs or study outside communities to Broome or elsewhere. Strong young people were reportedly independent, responsible and able to look after themselves and support others. They had the social and life skills to interact positively within their own community/culture and mainstream society. Resilient youth were said to be generally happy and have a positive outlook on the future. For example:

> *"Family, you know, taking notice of them. 'Oh you did a good job', or encourage them when they start going to TAFE or school or something. 'Oh that's good, you must keep going', all these things. So they know that these people are encouraging him and they care for them – and they've gonna be loving there, you know."* (Female, 65 years, One Arm Point)

> "*…um well they'd have to be a happy person…And I'd look at it like he's happy everyday and…he's enjoying his life, he looks like um, he'd be encouraging the other kids, giving them support and things like that."*
>
> (Female, 18 years, One Arm Point)

Respondents suggested that a strong community makes strong families and hence strong young people. Strong culture and community supports contributed to a strong community. Despite the breakdown of culture, Ardyaloon Community was perceived to still have a relatively strong culture, endeavouring to teach language and practise Law ceremonies. It was reported that many people knew some of their language, were knowledgeable in dances, stories and songs, and many, including young people, engaged in cultural activities such as fishing, hunting, and making spears and artefacts. When ceremonies and gatherings did occur, participants reflected that families could put their differences aside and come together as one group, allowing people to feel good, renew their spirit, connect to each other, their culture and environment. Sharing ceremonies (e.g., corroborees) gave people a sense of shared pride and identity. When there was a major crisis in the community and people really needed help, it was mentioned that the community would mobilise, with the Council and older people showing direction in gathering resources and providing support for the family/individual. For example:

> *"Well, like, when you got a family living in a community you are all seen as one. You're a strong community, the community is really strong. When you got a strong community you got strong people coming out of it and you'll have strong kids coming out. And your community also help you with*

problems or how to deal with something. You got strong community, you got strong children, and strong parents." (Female, 41 years, Broome)

"They really do it good when they um, we um, when we got Law happening, or the corroborees. People really um you see it, you see it all the time when people get together for, you know, ceremonies and things like that. They just put away their differences, they are completely different people. The love and the care, the respect, everything's all there. Yeah um but that only happens, you know, a few times during the year." (Male, 32 years, One Arm Point)

8.10 Summary and Conclusion

In summary, the findings from Study 1 showed town-based and community-based study cohorts were markedly similar in their responses. There were some differences in reporting between Elders, parents, carers, youth and service providers when looking at overall responses. Participants reported that the main problems impacting on remote Aboriginal children and youth were: family fighting, alcohol and cannabis misuse, lack of community-based activities and work, training opportunities resulting in boredom, suicidal behaviour, sexual abuse, the death of a parent, carer or close relative resulting in profound grief and loss, and education difficulties. Youth themselves cited lack of family and community support as a major problem, whereas Elders discussed the breakdown and loss of culture as being a significant issue impacting on youth and community wellbeing.

Study 1 participants reported that the most common ways remote young Aboriginal people demonstrated they had a problem was withdrawal or acting out behaviours or a combination of both. Female youth were more likely to withdraw, whereas young men were seen to externalise their difficulties. Young people experiencing significant distress engaged in suicidal or self-harm behaviour. A range of helpful and unhelpful coping strategies were identified. Helpful ways of coping included: youth seeking help from a trusted person and talking about their problem; family and friends providing support and spending quality time together; the community taking direction to deal with problems and access supports; and outside agencies providing support and counselling in the community, which was planned, coordinated and delivered by suitably trained and respected workers who had a relationship with the community. Unhelpful ways of managing youth problems included: young people using alcohol and substances to cope; lack of support from friends, family and the community; and poor responses from outside agencies, including lack of resources to provide support and counselling.

Study 1 identified risk and protective factors influencing the development of mental health and social and emotional problems in remote Aboriginal children and youth. Risk and protective factors were found to be operating within the individual, family, community and societal domains. Broome and One Arm Point respondents reported that the main risk factors were: lack of family and community support; alcohol and cannabis misuse; and family fighting resulting in a disconnected community. The main protective factors cited by participants were: support from parents/carers, extended family and community; living in a connected community (e.g., families coming together as one group); having community-based activities and opportunities

for young people; engagement in education, work or training, study; having positive self-esteem; knowledge and practise of culture.

Aboriginal youth wellbeing was mostly defined holistically, encompassing physical, mental, emotional, cultural/spiritual and social aspects of the person. Young people viewed as having good wellbeing or *liyan* were those who were emotionally well; in good health and free of substance issues; socialising with others in a positive way; and actively engaged in education or employment. A strong or resilient remote young Aboriginal person was described by participants as an individual who dealt with hard times and could help others; was motivated, independent, and responsible; had a good connection to family; and had the skills to manage in community/cultural and mainstream life. A comparison of the findings from the current research with other related research is presented in Chapter Eleven: Discussion.

In conclusion, the findings demonstrate that the social and emotional wellbeing of remote Aboriginal children and youth is impacted by a range of problems and associated risk and protective factors operating at varying levels of influence (e.g., individual, family, community, agency), as well as societal influences past and present. To build strengths and promote the wellbeing of remote young Aboriginal people, particularly those young people at One Arm Point, the findings suggest that goals for intervention would include: increasing connectedness of young people, families and the community to increase supports and decrease fighting and hostility; increasing engagement in education, work, study, recreation and cultural activities to relieve boredom, build skills and divert young people from antisocial behaviour (e.g., alcohol and drugs, fighting, vandalism); promoting cultural values, knowledge and

practices; enhancing leadership and management at the family and community level; and increasing resources and skills in outside agencies to provide community-based support and counselling.

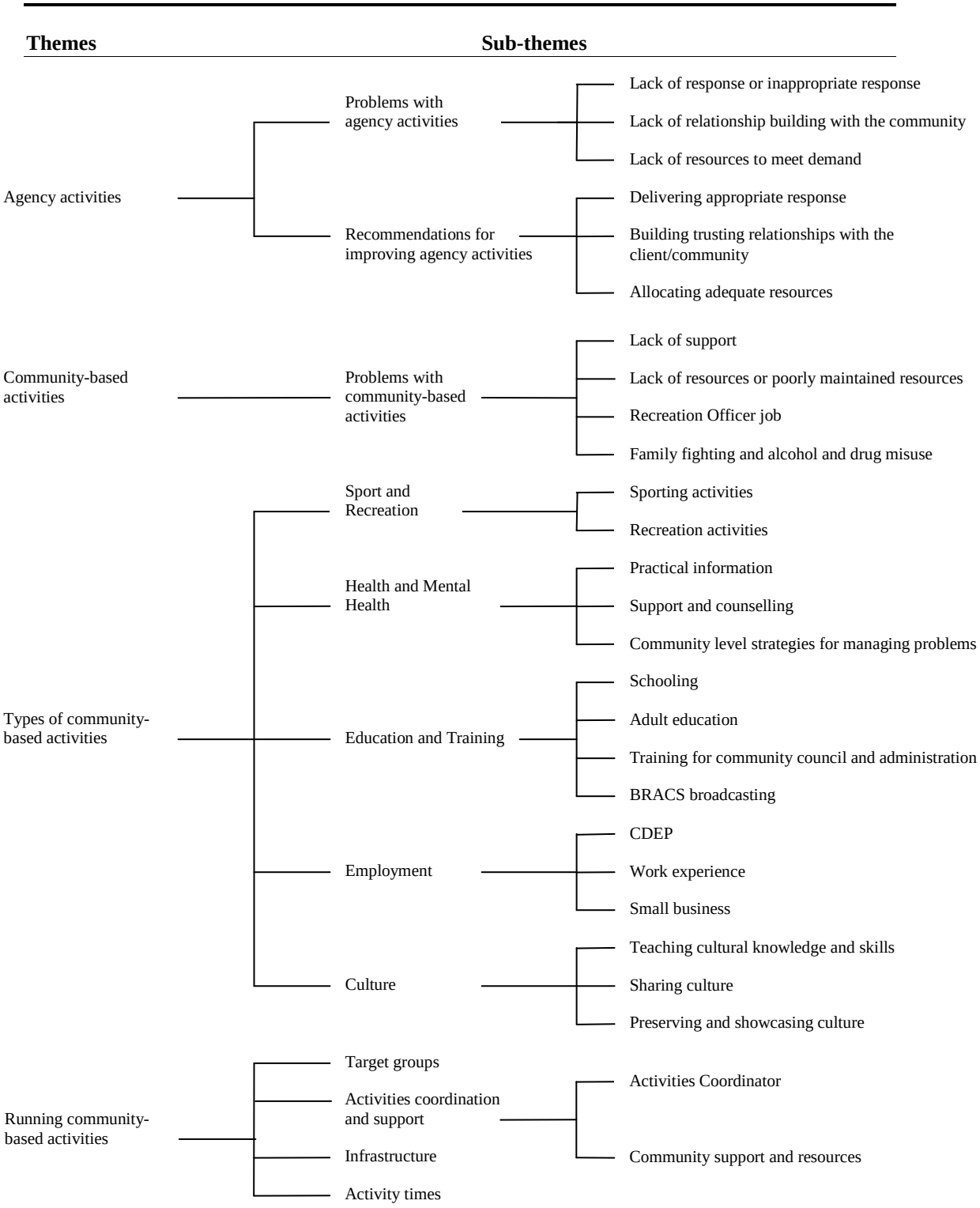
CHAPTER NINE

FINDINGS

STUDY 2: COMMUNITY SOLUTIONS

Study 2 aimed to identify and describe goals and methods for community-based intervention to promote wellbeing and resilience in remote young Aboriginal people, families and communities. This study involved 31 respondents from Broome and 41 from Ardyaloon Community, One Arm Point. Participants brainstormed ideas of types of activities and strategies for implementing activities they viewed as applicable to the research area (e.g., One Arm Point). The themes and sub-themes are described for each of the interview questions and summarised in part for ease of reference. Information drawn directly from interview transcripts is cited to further exemplify the findings. Permission was obtained from participants at the time of interviews for this use of interview information. Figure 2 provides a summary of the themes and sub-themes outlined in this chapter.

Figure 2. *Summary of Study 2 Themes and Sub-themes*



9.1 Social and Emotional Wellbeing Services and Programs

Firstly, discussion group respondents were asked to comment on the types of services and programs operating in their community which focused on the social and emotional wellbeing of young Aboriginal people and families. Participants were also asked to discuss any problems or pitfalls associated with agencies and community-based interventions and provide recommendations on improving service provision.

Question 1: *What are some of the activities or services you know of for young people or families that are run in (your) communities?*

What have been some of the problems with these activities/programs/ services?

Question 2: *What would have made them better?*

The activities identified by participants were those delivered by outside agencies to communities, categorised as agency activities, and those based in the community, categorised as community-based activities. Agency and community-based activities are discussed separately below.

9.1.1 Agency Activities

The main agencies identified by respondents as providing services for young people and families in West Kimberley communities (e.g., One Arm Point, Lombadina, Djarindjin, Beagle Bay, Bidyadanga) were Burdekin Youth In Action (Burdekin), Garnduwa Amboorny Wirnan Kimberley Sport and Recreation (Garnduwa), Western Australia (WA) Department of Health including Northwest Mental Health Service

(NWMHS), Department for Community Development (DCD), Kimberley Aboriginal Medical Services Council (KAMSC), Department of Corrective Services (DoCS), Aboriginal and Torres Strait Islander Commission (ATSIC) and the WA Department of Education and Training.

Burdekin and Garnduwa were agencies most often reported to be providing a service for children and youth in remote communities. Burdekin mainly focused on running recreation activities (e.g., DVD nights, discos) and delivering youth wellbeing programs (e.g., Resourceful Adolescent Program [RAP]: Shochet, Holland & Whitefield, 1997), focusing on dealing with conflict and relationships. Burdekin, as an agency providing support and counselling for 'at risk' young people also offered some emotional support to community-based youth when running activities in communities. Garnduwa provided communities with sporting activities (e.g., football clinics, basketball competitions), and coordinated leadership and cultural camps, such as the Argyle Young Indigenous Women's Leadership Camp. This camp, based at Argyle in the East Kimberley was a collaboration with industry and government agencies offering young women leadership, vocational, health and cultural education, as well as sporting and recreation activities. Garnduwa also worked with Notre Dame University in Broome to offer certified training for youth workers in sport and recreation, in order to build capacity in communities and increase community control of activities rather than reliance on Garnduwa to initiate and run activities. For example:

> *"Yeah we have set up the Certificate Two through Notre Dame or Notre Dame have. We've worked with them and they have developed that Certificate Two of Sport and Rec'. We are going to get hopefully one or two*

people from each of the communities to do that and that's set up as a block release and then later on down the track hopefully the communities can put aside a bit of money to employ these people and then they can be full time sport and rec' officers out in their communities." (Male, 25 years, Broome)

Participants reported that Burdekin and Garnduwa often worked together to deliver sport and recreation activities to communities. Both agencies worked mainly through community schools targeting school-aged children and youth. Where recreation officers were operating in communities, Burdekin and Garnduwa worked closely with them and could then engage older youth and community members who were already engaged with the community-based recreation officer.

9.1.1.1 Problems with Agency Activities

Several problems were identified in relation to some Broome-based agencies which delivered services to remote Aboriginal communities. The problems were reported to contribute to community people using the service less or not at all, ongoing frustration toward the agency and perpetuation of stigma about mental health and wellbeing services. The main problems reported by participants are summarised below.

Lack of Response or Inappropriate Response

- Agency either fails to respond at all or responds too slowly to referrals.
- Agency does not follow up with family or community reporting significant problems in young people.

- Agency worker is too closely related to the family or issue to intervene adequately.
- Agency worker is not adequately skilled or qualified to deal with complex problems (e.g., suicidal behaviour, child sexual abuse).
- Agency worker lacks localised cultural knowledge and skills to work with client or community in a culturally sensitive manner.
- Poor collaboration amongst agencies resulting in uncoordinated response or duplication of service, particularly in a crisis situation.

Some examples:

> *"And they're aware of what's happening out in the communities…but what they're doing about it, I don't know. And if they're aware of it, if they get an issue like that, they should be straight out there to deal with it. Not wait 6 months or whatever down the track."* (Female, 39 years, Broome)

> *"Yeah, they have to stop that because they think, organisations think, oh you have even the police, you have a 'Black' copper there, this organisation has another Black worker. Well they're there to liaise with the Black people but they got to stop and think, we're all relations. More or less, you know, related somewhere, you got to have someone who don't know the person, don't know them. No good sending out somebody who is local from this area."* (Female, 39 years, Broome)

"You oughta see them when there's a fight, when there's a suicide, every dog and his day is there. But in between no-one's there you know. And that's what the community needs." (Female, 44 years, Broome)

"what I've also noticed that people are sick and tired of different agencies coming different days, there's so much interruption they can't even get on with their own life. Those communities cannot get on with their own life. They are so um disrupted. 'Oh ATSIC coming out this week, police coming out this week, mental health coming out this week, drug and alcohol coming out this week, DCD coming out this week – we have no time to do even our own business…And they just go 'Ahh!' And the Council agenda gets chucked to one side." (Female, 40 years, Broome)

Lack of Relationship Building with the Community

- Not enough visits to the community.
- Not enough time spent during visits consulting with family and or the community.
- Poor notification of intended visits and purpose of visit.
- Lack of continuity of workers visiting the community.
- Lack of clarity about the type of service the agency offers, their role and responsibilities, and how services can be accessed from the agency.
- Agency office is uninviting or inappropriate, particularly for young people.

For example:

> *"No nothing. He come here, he come over there, he look around there, he gone. He never sit down with the people."* (Male, 59 years, One Arm Point)

> *"Yeah cos I mean there are agencies out there that can help them, it's just awareness too. Like cos there are agencies can help but they're just not aware of them, or they get intimidated. They're not gonna walk into this big office and the reception is right over there and they have to actually walk from the door right over there and before that they'll just turn around and walk out, you know, they're like, 'Oh na'…Yeah, it's too like institutionalised or something. You want a big sofa out the front and you want, you know, like kind of like magazines that young people read and maybe cool posters on the wall and I don't know, something like that."* (Female, 23 years, Broome)

Lack of Resources to Meet Demand

- Agencies are under-resourced to meet community expectations and service demands, such as spending time to build trusting relationships and continuity of the service or program.
- Agency programs are under-funded and only funded for a short time (e.g., 6 months to 2 years) and fail to meet their goals, such as covering several communities with too few workers.
- High staff turnover in agencies - difficult to attract and retain skilled workers to remote areas.

- No counselling, therapeutic service based in communities.
- Few services based in Broome which offer ongoing counselling, therapeutic intervention, leaving little treatment and follow-up intervention.
- Few resources in agencies for preventative intervention.
- Little accommodation available in the community for agency workers visiting the community.

For example:

> *"You know what's really scary stuff, with all this community development stuff, you know with sort of staffing issues and stuff, we just don't have the man power to have a regular face at Djarindjin or One Arm Point, which is really sad."* (Female, 43 years, Broome)

9.1.1.2 Recommendations for Improving Agency Activities

Several suggestions were given by agency and community participants on ways to improve service provision to remote communities in the area of social and emotional wellbeing. These recommendations are summarised below:

Delivering Appropriate Response

- Act on referrals in a suitable time-frame.
- Service, program must be in line with community priorities and needs.

- Whether agency workers are Indigenous or non-Indigenous, they need to be adequately skilled, neutral, and have cultural competence pertaining to the community(s) and, people with whom they work.
- Agency workers need to be allocated to the same community over time.
- Agency workers need to be suitably resourced for the job they are required to do and be able to access good supervision and support.
- Do not send out workers too closely related to the family/client.
- Collaborate and coordinate service, program delivery with other agencies (the perception was that this was improving, particularly in crisis situations).

For example:

> *"And making sure the person they send out to speak to the parent is not somebody they really know, or might be related to because the parent won't speak to them cos they don't want their things that happen within their own family to be told to somebody they really know, you know might be related to. I reckon they should just send out a qualified person."*
> (Female, 41 years, Broome)

> *"I guess getting everyone working together is one of the most important things we can do. Garnduwa and Burdekin have already started doing that and now trying to tie in people like JJ (Juvenile Justice) and some health mob."* (Male, 25 years, Broome)

Building Trusting Relationships with the Client/Community

- Visit communities more often for longer periods of time, allowing time to form trusting relationships with community people, particularly young people.
- Spend time learning the local history, culture and relevant issues from the community people you are working with.
- Provide the community with more information on agency and worker roles and responsibilities, such as what service they offer, how to access it and what referral procedures to follow.
- Consult more on the nature of the intervention. Find out what the client's/family's/community's expectations are and what they deem appropriate and likely to work.
- Inform and consult with the Council on proposed service delivery, programs.
- Provide ongoing feedback to the client/community on the intervention or program.
- Extend relationships beyond community schools to the rest of the community, as school staff is transient.
- Make agencies visible, easily accessible and inviting.

Some examples:

"And maybe someone from [agency name] instead of staying in the office and sending heaps of emails, getting out there and networking."

(Female, 40 years, Broome)

"Oh, it depends on the individual, but it can take you months to build it. Yeah, cos before you can get anywhere, you got to build up a relationship, and trust! You don't expect them to create miracles on your first visit, or third visit." (Female, 41 years, Broome)

"Yeah sometimes it's a challenge with the kids but um I've noticed that I try and not take an approach that sort of scares them off, like I try and get a bit more social with them too, not just run clinics. We got to do this and we gotta do that, yeah I try bit more social sometimes and like sit down after clinic and have a 'yarn' about what's been happening you know, what fish have been caught around the place and yeah and I see that tends to really make them um enjoy it when you come out a bit, and they become more friendly with you and open up to you a bit more and talk to you a bit more then they know you next time, yeah it's a good way of getting things across."
(Male, 20 years, Broome)

"You know, we'd like to see them come here and sit down. Get the whole family together." (Female, 52 years, One Arm Point)

Allocating Adequate Resources

- Pool resources across agencies, such as sharing vehicles, project funding.

- Plan programs with ongoing recurrent funding to realistically meet goals and outcomes that are relevant to the community.
- Provide funds for workers based in communities to provide support, counselling, preventative intervention. The positions need to be funded, not under Community Development Employment Projects (CDEP), with ongoing training and support from agencies.
- Allocate funding to early intervention, including skill-based programs for youth, such as RAP.

For example:

> *"And making sure that agencies that are going out know who else are out there as well, so if ATSIC is going so we don't have just two people travelling out in one car. This is one of the reasons we got together with Burdekin. If they're going out we only have two people they can hop into our car rather we can save costs there - that's one way of cutting costs so we can spend money on more decent things and so if we can work in with some of the other crew just working the program around there so things are coordinated a bit better and that money is being spent where it should be."* (Male, 25 years, Broome)

9.1.2 Community-based Activities

Many participants reported that there were few activities happening for youth and families in remote communities, particularly One Arm Point. One Arm Point respondents identified several activities which had occurred in their community in

the past, however these activities were not operating at the time of Study 2 interviews in 2003.

Participants reported that the main activities which had occurred in One Arm Point included sport and recreation activities, such as organised sporting teams, basketball and football competitions, camps, discos and DVD nights. These activities were run by a community recreation officer. Some sport and recreation activities were now run by outside agencies in collaboration with the One Arm Point School. A youth drop-in-centre had functioned for a short time, run by a community member. The drop-in-centre provided games and activities for children and youth. Funding for a "Youth Suicide Prevention Project" was allocated to the community for cultural activities, such as family camping trips during which Elders and parents could teach young people about their history and culture. However, this project had stopped and some of its funding remained unallocated. The women's group had disbanded and the women's centre remained mostly unused. The men's group had also ceased meeting. Overall, there was a lack of activities to improve the social and emotional wellbeing of young people and families in One Arm Point. Some examples:

> *"The kids are generally bored most of the time. Um basically they haven't got any activities, after school activities run in the community."*
> (Male, 32 years, One Arm Point)

> *"Before when they build that oval, the One Arm Point oval here, um that went with the community hall. So back then when they had the oval they had the local Bardi football team here and that brought a lot of young people in*

there, teenagers all the people like, you know, that were playing for the side. And you even had the young kids coming around there and joining in, and hanging around, not only kicking 'round the football but just generally running around and having fun. That's what they had an area to be in, you know, safe and, area where they can just, you know, tire themselves out without getting into any mischief. So when the oval was up there, there was um footy, football happening. We had basketball competitions. We had really strong basketball competition happening, going back I think late eighties, early nineties, and we had heaps of teams, like man teams from here and woman teams which involved like sorry the man, woman teams plus an under 16 side, like we also had our children involved as well. And we had teams coming over from Djarindjin, Lombadina, to One Arm Point. So all up I think the place had about thirty odd teams in the competition playing a couple of nights a week and that always involved you know the whole community, anyway so that was really good for the place... A lot of parents were there as well, getting involved as well, you know, it was a good social thing, you know." (Male, 32 years, One Arm Point)

"We had activities down the beach, you know. A bit of volleyball and basketball down there, and they used to play baseball down the beach. Just somewhere, something different all the time."
(Male, 38 years, One Arm Point)

"Well see that women's group that's another issue too. That's been operating for x amount of years but yep is it really happening, it's not. You know,

they've got all this equipment but because a couple of women who know the equipment don't have the time anymore to show the others how to use it, or others don't want to learn, you know the whole place just comes to a standstill." (Male, 42 years, One Arm Point)

9.1.2.1 Problems with Community-based Activities

Participants reported that the activities run by the community for young people and families had not been sustained year to year. Respondents from Broome and Ardyaloon Community described some of the limitations and problems with community-based activities which contributed to their lack of sustainability. The main problems are summarised below.

Lack of Support

- No-one in the community taking ownership and responsibility of running youth activities.
- Reliance on outside agencies to run activities.
- Lack of support from Council for youth activities, mainly due to competing priorities, such as daily running of the community and no-one managing smaller projects.
- Lack of general support from parents and families for young people.

Some examples:

"Then I think, there's a few people that used to, you know, try and get in there and um be the recreational person, you know. Heaps of good people, good ideas, you know, and a lot of drive there in them. I think over the years they felt a little bit um left out on their own, because they didn't get any support. That's only it could be, you know, community support, Council support, family support, all around, all areas, just general support, you know, for that person. Whether it be money, I'm not too sure, or transport. Transport is a big, big problem, and that's everywhere. But that's a big one for the recreational officer. I've spoken to a few people who have tried it and basically most of the time it's transport, just getting the gear together, transporting the children to a certain place on time and everything, organising their projects or activities, you know, really hard for them. And that's probably most of the time, over time they sort of generally lose interest." (Male, 32 years, One Arm Point)

"I think lots of job just lack of support, I think because how communities are structured now, like they've got their CEOs very much under the pump with providing all the accountability stuff for grants received and maintaining that side of things, you know, the big million dollar grants and stuff like that you know. Um and there is no-one to actually look after the little projects, like those things, you know." (Female, 41 years, Broome)

"One of the things that we lacked was no supervisors and again no commitment as well you know." (Male, 49 years, One Arm Point)

"I think basically just the people that ran it, the committee, just a little bit of um extra work that they put in back then. I think after that two people sort of left the community um nobody else took over and it just sort of was forgotten about. Not forgotten about, everybody still wants to see a basketball competition happening of course." (Male, 32 years, One Arm Point)

Lack of Resources or Poorly Maintained Resources

- Lack of funding and resources made available by the community administration for youth activities (e.g., lack of vehicles to transport young people).
- Lack of funding from outside sources, due in part to lack of community awareness about accessing this funding.
- Some funds and equipment mismanaged, missing or stolen.
- Some equipment vandalised.
- No-one designated to be responsible for equipment.
- No clear rules about secure storage and use of equipment.
- No-one taking responsibility for the maintenance of community infrastructure, such as the hall, women's centre, football oval, basketball courts. No workers to maintain this infrastructure.
- Few funds available for restoration and maintenance of infrastructure.
- Increasing regulations needed to run activities, such as boat licenses, indemnity insurance - skills and funds community members do not have.

Some examples:

"Yeah, they were good but they had no help, no support. They had no money to buy stuff for the disco, like food, drinks. We had to sell drinks to cover our costs." (Female, 46 years, One Arm Point)

"Well in the past it wasn't run properly, um some of the funding was being abused and we thought we lost it which is one of the reasons why we haven't tapped into that area anymore." (Male, 42 years, One Arm Point)

"when you listen to the oldies and what's happened here in the past, they will tell you that we have had all these for the kids and within 3 months everything gets wrecked." (Female, 47 years, One Arm Point)

"And if it's not wrecked it's taken by certain groups."
(Female, 49 years, One Arm Point)

"I was hassling the administration for years …Come on let's get the oval up and going and we'll do stuff there, I'll do stuff with kids, I'll even help coach a footy team and for the adults and stuff like that, but it never, and the money just kept getting shifted, and in the end I thought, oh well, I'll give up."
(Male, 43 years, One Arm Point)

"The footy oval over there needs fixing up. They didn't take care of it, it hasn't been used in a long time." (Female, 35 years, One Arm Point)

Recreation Officer Job

- Underpaid - the worker was paid CDEP.
- Difficulty managing family conflict, criticism from community members.
- Given little training.
- Largely unsupported.
- Prone to burn-out.
- Little incentive for community members to take on this challenging job.
- Lack of skilled and motivated people to take on this job.

Family Fighting and Alcohol and Drug Misuse

- Fighting amongst families resulting in lack of cohesion in the community, making it very challenging for the community to work together to run activities or participate together in activities (e.g., women's and men's groups disbanded due to feuding).
- Some families/young people discouraged from taking part due to conflict with other family group.
- Jealousy and criticism toward community members taking on roles, making it hard for these people to do their job (e.g., recreation officer, women's centre coordinator).
- Alcohol misuse and subsequent fighting had disrupted some community activities (e.g., discos, basketball carnival).
- Alcohol and drug misuse contributed to lack of motivation in community members to help with or participate in activities.

Some examples:

> *"And with the families how they're interacting or you know the fighting, it's like ok let's start this basketball club but hey I'm not going cos he's going [all agree]. And that's where it's really hard."*
> (Male, 31 years, One Arm Point)

> *"We were running for good and then the criticism started to come in...Well I got sick of everybody bitching about everything in this community...and non-one didn't want to help to work to do anything."*
> (Female, 52 years, One Arm Point)

> *"we were just starting it off, you know, like even just sitting down and just talking about what should happen and having a cup of tea and biscuit or sandwich, just talking. And that was starting up really good, you know, we go down the beach, just clean up a bit of area, so we can sit down and do all our stuff there, and it was building up to be a really big thing, you know. Spear making, boomerang making, but [sighs] when fighting start getting involved with stuff like that, well that's what broke all that up…When the Elders start getting involved, nobody won't follow them and for it to work the Elders got to play a big, big role in the men's group."* (Male, 38 years, One Arm Point)

9.2 Types of Community-based Activities

Broome and One Arm Point participants were asked to nominate activities they deemed appropriate for young Aboriginal people and families living in remote communities, in terms of building strengths to deal with some of the social and emotional problems impacting on young people.

Question 3: *What would you like to see happen in your community to help young people and their families deal better with problems?*

The respondents identified a broad range of resilience building activities to promote the wellbeing of remote young Aboriginal people, families and communities. Some of these activities had been implemented previously in One Arm Point and surrounding Aboriginal communities and some examples were drawn from activities currently happening in Aboriginal communities across the Kimberley. The activities were grouped according to five main themes namely, sport and recreation; health and mental health; education and training; employment; and culture, which are outlined below.

9.2.1 Sport and Recreation

The activities most favoured by participants, particularly youth, were those related to sport and recreation. Respondents suggested that providing sport and recreation activities for young people would relieve boredom; provide a diversion from alcohol and drug misuse, fighting and vandalism; provide adult supervision and support; as well as offer opportunities for young people to socialise together and seek peer

support, decreasing their isolation and improving social skills and self-esteem. The recommended popular activities were as follows:

Sporting Activities

- Organised sporting teams and competitions (e.g., football, basketball).
- Beach volleyball, aerobics for young mums, yoga for women, gym, indoor sports, swimming lessons, boxing, karate.
- Fishing competitions.

For example:

> *"And basketball. Had a lot of basketball here, football. The boys used to play down the football oval there. Mmm, we had teams made up for basketball…and I don't even see why it's not happening today! I reckon there should be more, the kids won't get bored. You know, like in the afternoon, after kids finish school someone should say, 'Well ok, we'll make ourselves available for those kids who want to go out.' Send notes to their parents and say, 'Right look, can I take the kids out?' And ask the community for a vehicle or something, the old one. They can supply the fuel. And bring them down to Djarindjin sometimes for basketball."*
>
> (Female, 52 years, One Arm Point)

"You know most of these kids are really good basketballers. They love it! When it's basketball competition on, it's paramount. Everyone goes to town, they'd walk to town if they could, you know. They just love it!"
(Female, 47 years, One Arm Point)

Recreation Activities

- Youth drop-in-centre where recreation activities could occur, such as games (e.g., pool tables), music (e.g., forming a band, lessons), dance lessons, art and craft (e.g., creating a graffiti wall/mural).
- Discos and DVD Nights.

For example:

"Could have after school activities. Kids need a youth centre with their own equipment, own place." (Female, 35 years, One Arm Point)

"I think social activity also, where people gonna interact with each other."
(Female, 41 years, One Arm Point)

"Music. Music'd be another really good thing as well because we do have youngsters that are quite capable of playing music over here."
(Male, 30 years, One Arm Point)

"Well the rec' officer could do discos and things like that."

(Male, 43 years, One Arm Point)

"They should have more DVD nights like the other night. Like a new release like every weekend." (Female, 19 years, One Arm Point)

9.2.2 Health and Mental Health

Study 2 participants indicated that there was a significant lack of community-based activities related to health and mental health for young people and families. The following activities were suggested to improve the health and wellbeing of remote community people, particularly young people.

Practical Information

- Health and nutrition (e.g., healthy cooking) for parents (e.g., young mums with babies, small children)
- Smoking, alcohol and cannabis prevention and harm minimisation
- Sexual health and sexually transmitted infection (STI) prevention in the context of relationships
- Pregnancy
- Parenting skills for all childhood and adolescent ages and stages
- Managing conflict and anger

Support and Counselling

- Relationships

- Managing anger, jealousy, fighting
- Suicide
- Sexual abuse
- Depression, grief and loss
- Gambling and neglect
- Overcoming shame, building self-esteem
- Coping skills
- Have a qualified counsellor based in the community.
- Train local people already fulfilling support/counselling roles (e.g., to recognise signs and symptoms, talk to youth with problems or in distress; listening skills, empathising, problem solving).
- "Feel good" activities (e.g., health and beauty, relaxation).

For example:

> *"Oh, one thing I think would be good and that'll break down the thing of being shame and that is they need something that's open them up a bit, so they're not so shame, you know. And then most of them might get more involved and, I don't know, speak up a bit about things that they want and need and you know, to other people. Um something that's gonna open them up a bit, to get them out of being afraid of what other people think about them."* (Female, 22 years, Broome)

> *"Yeah and how to speak up for themselves you know."*
>
> (Female, 52 years, One Arm Point)

Community Level Strategies for Managing Problems

- Have community meetings to talk about problems and solutions (e.g., family fighting, drug and alcohol misuse, gambling and sexual abuse).
- Participate in bush meetings with people from other communities to discuss problems and promote healing.
- Provide more designated space around the community for socialising (e.g., put tables and chairs outside the shop).

For example:

> *"I think we have to interact more, even though we have great big families here, we don't sit down as a family in a big group and sit down and talk about the problems. Like before your Elders, used to sit down and look at and discuss all the problems. We as individual family groups at One Arm Point Community we don't sit down enough in a big circle, have a BBQ every month or two and just get together and talk about their problems. We don't do that at all, that's just changed so much. To change that I think we need to do that, um families to have regular meetings, sit down, have regular BBQs whatever, get together and talk about it and look at directions. We don't do that enough even though we support ourselves indirectly, we don't sit down all together as a family on a regular basis and talk about our problems."* (Male, 36 years, One Arm Point)

"The communities should get together like a meeting and say, 'Alright we're going to talk about this gambling issue. Not to stop you playing cards because we all know you all love playing cards. But it's got to be set times. That time you finish, no more gambling. Go home, feed your kids, make sure your kids are clean, fed and in bed.' You know half the time the mother's using all her money, all her pension. The kids come home, no food, no electricity." (Female, 41 years, Broome)

9.2.3 Education and Training

Participants reported that there were shortfalls in the educational achievement and attainment of remote Aboriginal children and youth, as well as a lack of vocational and life skills making it very difficult for young people to seek and undertake employment, training or study. There was also a lack of facilities in the community for education and training, for example:

"We've don't have any learning facilities here. You know, if somebody wanted to do some sort of, a distance education thing, there's nowhere here. You know, there's nowhere to go and search for a job."
(Female, 47 years, One Arm Point)

The main suggestions for initiatives to increase education and training opportunities for remote community children and youth were as follows:

Schooling

- Parents encourage their children to attend school.
- Develop a Peninsula (local) high school for One Arm Point and surrounding communities. Children can board there during the week.
- Refine the school curriculum and teaching methods to make education more culturally appropriate for remote Aboriginal children.
- Include culture (e.g., Aboriginal language) in the curriculum but also provide education equivalent to mainstream schools.
- Make family welfare payments contingent on parents sending their children to school.
- Improve hostels/away from home support for children going away for schooling so they are looked after, safe.
- Raise awareness about education opportunities outside the community and provide support to young people to access these opportunities.

For example:

> *"Yeah the principal of the school keep a record of enrolments, if the kid doesn't come to school for three weeks, send that information through to Centrelink. Automatically the pension, single mother's pension or whatever they are on gets cut off. Give them a notice first so they know."*
>
> (Female, 41 years, Broome)

Adult Education

- Have a designated space in the community (e.g., school) for an adult education centre
- Provide internet and study facilities
- Provide education and vocation courses, including TAFE courses based in the community
- Small business information (e.g., tourism, aquaculture)
- Literacy and numeracy
- Computer skills
- Job skills (e.g., writing applications, CVs)
- Financial management and planning
- Leadership, mentoring

Some examples:

> *"Adult education, adult education learning centre is, I'm really, I've really been trying to push for that. …Cos a lot of people are doing courses, like from Edith Cowan and Notre Dame or other places and there's no-where for them to go and study and keep their books and get onto a computer."*
> (Male, 43 years, One Arm Point)

> *"Study people, you know, they can go and do their study there cos over-crowding of people in houses in this community is ridiculous, and they have*

all sorts of social problems. Study is just one thing they are not interested in at home, but if they had somewhere to go they could."
(Female, 41 years, One Arm Point)

"How are they going to get a job in the future too. I mean if they leave here you've got to be able to even if it's a touch screen working at the bottle shop, you've still got to be able to know, whether you like it or not, do some sort of IT work." (Female, 47 years, One Arm Point)

"Yeah so trying to break that cycle where I guess this young bloke, his old man or you know is waiting for his next dole, next week so he's waiting for CDEP next week - so that sort of stuff, just trying to help young people out of that. Show them how to draw up a budget, but it's not going to happen straight away, but you can teach them bit by bit. That's a skill you can teach people you know - budgeting, putting money aside for a rainy day or saving to buy a car to go fishing or buy a new rod or something like that. I mean that's a skill that needs to be learned." (Male, 25 years, Broome)

Training for Community Council and Administration

- Leadership and governance (e.g., building a community management structure, decision making - including the community more in decision making).
- Community planning and development both short and long-term (e.g., for housing).

- Policy and workforce development and management (e.g., defining roles and responsibilities of wardens, support structure for workers).
- Program/project development, such as skills in writing funding applications and administering funding.
- Disseminating information, skills to community people (e.g., seeking funding).

BRACS Broadcasting

- Training in the use of Broadcasting for Remote Aboriginal Communities Scheme (BRACS) equipment to broadcast TV and radio messages (e.g., health, mental health promotion messages, community information).
- Recording and preserving old people's stories.

For example:

> *"They can have their own radio operating from the school, they can even come here and do it, because Goolarri don't own this, the community own this. It's a community radio station. So anybody can come in, even if they wanna get on the air, do a 1 hour program, but we need someone to manage it, you know."* (Male, 42 years, One Arm Point)

9.2.4 Employment

A major concern for community participants was finding ways to generate employment and income in their community and outstations. This was due to few

paid jobs available in the community, the longstanding dependence on welfare and CDEP payments for personal income and the community's reliance on outside government funds to sustain itself. Participants reported that engagement in employment or vocational training either in or outside the community was related to increased income, direction, motivation, confidence and self-worth in young people, as well as reduced reliance on welfare, drinking and drug taking. The One Arm Point Aquaculture Hatchery was cited by community participants as a positive example of young males actively engaged in work (albeit CDEP) and vocational training. The hatchery was also becoming an income generating business for the community. Tourism ventures initiated by some families in One Arm Point were also reported as financially viable small businesses creating not only a livelihood but a family work ethic and pathway for some young people to training and paid employment. Tourism was also seen as a way to expose young people to outsiders, particularly non-Aboriginal people, building their confidence and skills in mainstream culture. The main recommendations for employment activities are listed below:

CDEP

- Re-evaluate and remodel CDEP.
- Assign wages to legitimate jobs (e.g., wardens).
- Monitor CDEP, e.g., only pay those people doing the work.

For example:

"They don't want to do anything and you can't get them to go over there and sweep around the veranda or anything like that. And until the CDEP program is operating good, it's virtually impossible to get anyone to do anything here unless someone's got the motivation to get out there and do something for the place on their own steam."

(Male, 42 years, One Arm Point)

Work Experience

- Provide work experience opportunities in and outside the community (e.g., at the shop, office, hatchery).
- Expose young people to jobs and Aboriginal workers in and outside the community (e.g., take them to see Garnduwa, Kooljaman at Cape Leveque).

For example:

"Work experience, having a part-time job in the school holidays, at the shop a few hours a week so they get used to work. Give them some pay or top up CDEP, not full pay. The ASSPA committee did focus on getting kids to do work experience in the hatchery in the holidays, give them something to do. Or Kooljaman has said they will supply work experience to those who are interested. Especially in Christmas holidays. Kids need something to do in the holidays." (Female, 35 years, One Arm Point)

Small Business

- Tourism, e.g., tours, accommodation, bush trips
- Grocery or supplies store
- Plant nursery
- Sell cultural art and craft, artifacts
- Community market - sell art and craft, food, plants for other community people and tourists.

For example:

"I reckon that there'd be a whole lot of tourists willing to pay a pretty significant amount of money to be given a guided tour like on the Minyirr Park sort of concept, um to the young person. For example, to take and show 'em the sites and do a bit of fishing on the way. I mean, it's simple to achieve really and it can be so effective and then that young person then has their own source of income, they feel good about what they're doing, and they're flat out with tourists which is great." (Male, 34 years, Broome)

"And I think it could also come, you've got all these skills, and if they would, you know, like the art and the carving and that sort of stuff, that could even start off a small enterprise as well." (Female, 43 years, Broome)

"Like Djarindjin, they do market, Saturday markets, every Saturday. Not every Saturday, every 3 months or month, or something like that. And then

anybody who got anything to sell, you know, cook feed and sell it, and plant or whatever, jewellery, they make you know. Jewellery and stuff like that. They get a table and they only pay $5 for the table, and then the people walk 'round, walk 'round, buy pastries, feed here, how they do it in town, you know, they do that in Djarindjin and that's good! … And, you know, it would be really good to have that sort of thing. Maybe somebody might make like they do in trochus shell, maybe jar of trochus shell meat to sell for $5 or something like that, you know, or fish or rice. That'd be really good. If they think of that, you know, that way, to get people to mix with one another. Yeah, so that's another way of mixing together, you know, people mixing together. They usually, they had like bullock meat, goorlil meat, and fish and rice and stuff like that, from the sea. Another time they was buying some crab off one family. It was good." (Female, 65 years, One Arm Point)

9.2.5 Culture

Broome and One Arm Point participants identified cultural activities as some of the most important activities required to promote youth and community wellbeing. Participating in cultural activities was seen to benefit young people, families and the community in terms of bringing people together and increasing community cohesion; connecting young people to their families, particularly Elders; and perpetuating cultural values. Engagement of community members in cultural activities, such as Law business and ceremonies was also seen by participants as a deterrent from family fighting and alcohol misuse, both disallowed at these activities. Learning cultural knowledge and skills was perceived as resilience building for young people and the community, promoting positive identity and pride, self-esteem and respect.

Some of the cultural activities suggested were already happening in certain family groups, however the consensus amongst respondents was that cultural activities needed to be more widely available to all families and young people. For example:

> *"We do some culture stuff during NAIDOC, but we feel, like from, as school staff we feel that's sort of not enough for the kids. It would be good if, cos that only happens once a year NAIDOC. A lot of kids do get it at home automatically with their family but there's a lot of them that are just missing out. Perhaps there could be something set up that um, within the community, maybe later on after school. Like some days you could probably have your sporting activities, other days you could probably have cultural day...Very important yeah. Which would give the kids a lot of pride back, their self-esteem, their confidence. All theses types of skills would come with those types of things, yeah."* (Male, 32 years, One Arm Point)

The cultural activities seen as important were as follows:

Teaching Cultural Knowledge and Skills

- Learn hunting, fishing, cooking
- Bush tucker and bush medicines
- Bardi language
- Songs, dances
- Boat handling, raft making, navigating local tides
- Birthing and child-rearing

- One Arm Point history (e.g., Sunday Island Mission)
- Make cultural artifacts (e.g., spears, boomerangs, hairbelts)
- Provide localised cultural awareness training – the community trains outside workers who work with the community, in their history and culture.

For example:

> *"Probably just teaching the younger boys here how to make boomerangs and spears and things like that, you know. Setting up a traditional workshop where the old men could come in, or any men could come in and start making boomerangs and stuff. Teach the younger ones how to make them. Or go out bush and walk around looking for certain trees."*
> (Male, 42 years, One Arm Point)

> *"With stunning the fish, poisoning, how to find them and stuff, and how to do it and, you know, like taking them out making spear maybe. How to get turtle, you know, turtle hunting and going out and teaching them about reef, what time to go to reef or even handling boat, boat handling, you know. Um, because a lot of kids like to go on boat."* (Male, 38 years, One Arm Point)

> *"Girls can go and learn how to do bush medicines out in the bush. Cut the trees, bark, whatever, and sit down and write up a little story about it what they did out in the bush."* (Female, 52 years, One Arm Point)

Sharing Culture

- Spend time with the old people
- Share stories about culture and history
- Practise Law
- Camps to Sunday Island, outstations
- Community gatherings down the beach with BBQ, corroboree
- Have more Elders in the school teaching Bardi language
- Visit other communities to exchange culture

For example:

> *"They are! They would be, but you need someone to be there with them, not just to sit out and wait. Get involved, take them, show them. Don't just go to the fishing place and say, 'oh here's your spear, now you go,' you know. Go and walk in the bush, look 'round for bush food that you can feed them. Go and walk with them on the beach, spearing or fishing or something like that. When they catch whatever they catch, show them what to do, how to cook it. Things like that. You can't just expect to go there and sit down and make them aware. You gotta show them."* (Female, 39 years, Broome)

> *"Get the older people involved. Get them out in the bush. Teach them the cultural way of fishing, how to make spears, boomerangs, stuff like that you know. Listen - sit down, listen to stories."* (Male, 36 years, Broome)

"Singing and corroborees…Whole community should come join in"

(Female, 73 years, One Arm Point)

Preserving and Showcasing Culture

- Community culture centre (e.g., display culture and history, teach culture).
- Culture room at school (e.g., make artefacts, display culture and attract parents and grandparents into the school).
- Record old people's stories
- Record language

For example:

"Mmm, but more my point was um - if you've got outsiders coming in bringing skills in that they're gonna share or teach, before you do that, why can't One Arm Point people hold a training session for all those people, 'You come to our training session and we'll teach you about One Arm Point.'…Teach them what One Arm Point is. It's an Aboriginal community, these are the kinds of people who live here. We have different kinds of families here, some of us trochus, some of us fish, some of us work in the store, some of us don't do anything. Um this is the history of One Arm Point, these are all the dramas we've had over the years. We still have family fighting over the airport, the runway, and all those service providers or

training providers are sitting there being taught by One Arm Point people about One Arm Point." (Female, 48 years, Broome)

The main activities identified by participants to build strengths and promote social and emotional wellbeing in remote Aboriginal children and youth are summarised in Table 14.

Table 14. *Activities for Promoting Remote Aboriginal Youth and Community Wellbeing*

Health & Mental Health	**Sport & Recreation**	**Education & Training**	**Employment**	**Culture**
Information on: Nutrition Alcohol & drug prevention Sexual health Pregnancy Parenting Support & Counselling: Relationships Conflict & anger Suicide Depression Grief & loss Sexual abuse Community Strategies: Alcohol & drugs Fighting Gambling Train Community People: Support, Counselling Youth Counsellor Bush meetings for healing	Organised sporting teams & competitions Football Basketball Youth drop-in-centre Older youth space Music Dance Games	Local high school Culturally appropriate curriculum Adult education centre Training on: Literacy & numeracy Vocation courses Small business Computer skills Job skills (e.g., CVs) Financial management Leadership Mentoring Train Council/Admin: Governance Management Community development Policy & workforce Project development Funding applications & administration BRACS broadcasting	CDEP monitoring More paid jobs Work experience Small business e.g., Tourism Community market	Teach Cultural Knowledge & Skills: Language Songs, dances, stories hunting, fishing History Share and Preserve Culture: Family BBQs Ceremonies, corroborees Camps – Sunday Island Spend time with old people Exchange culture with others Community culture centre School culture room Record old peoples' stories Local cultural awareness Training for outside workers

9.3 Running Community-based Activities

In the second half of Study 2 interviews and discussion groups, participants were asked a range of questions to seek their ideas and opinions on the best ways of implementing community-based activities in remote Aboriginal communities. The

findings in this section are grouped according to each of the study questions. Additional themes generated from the data are also incorporated.

9.3.1 Target Groups

Participants were asked what people or groups in the community should participate in activities.

Question 4: *Who would take part? Why these people?*

Participants revealed that youth wellbeing depended on the wellbeing of the whole community. Therefore, respondents indicated that activities to promote wellbeing and build strengths in young people needed to be targeted not only at young people but all community members, including those from each of the family groups and outstations. Some groups in the community were identified as being more vulnerable than others, requiring particular focus of activities, such as young people dealing with early parenting and relationship issues (e.g., conflict, child rearing, managing finances), and youth who were not engaged in school or work. For example:

> *"there is nothing for the young mums, you know, and most of our young mums here are adolescents themselves, most kids here are having babies at 18. So they're now locked into that, 'God I've got this baby.' What do they do, other than smoke dope and drink and watch tv?"*
>
> (Female, 47 years, One Arm Point)

Youth participants commented that recreation activities directed at children and youth (e.g., drop-in-centre, DVD nights and discos) would be best run with separate age groups, such as children and adolescents. Older youth requested a separate "youth space" for their activities. Most participants reported that some cultural activities needed to be run with separate groups of girls and boys.

Parents were seen as a group requiring skill-based activities, such as information about health, social and emotional issues, including parenting. The community men interviewed perceived these issues as important to them and not just "women's business", thus requested involvement in these activities. In particular, they wanted to improve their knowledge and skills for recognising signs and symptoms seen in young people experiencing problems and helping young people with problems. The consensus was that separate groups for men and women would encourage engagement in talking about problems and ways of dealing with these problems on a more personal level.

Most town and community-based participants wanted activities (e.g., sporting competitions, camps, some cultural activities, skill building) to include young people and families from neighbouring communities, such as Beagle Bay, Djarindjin and Lombadina. This was seen as a way to increase socialisation for young people and enhance their exposure to others outside their community, provide families more access to their extended families and friends in other communities, as well as for community people to exchange ideas with others. For example:

"I would like to see that because I think it's important that the kids learn to mix with as many people as they can outside of their safety group and learn how to interact with people that they may not like, you know because life is like that." (Female, 35 years, One Arm Point)

"It would be good because a lot of families um travel between the communities, not only between these two communities now, but we also get a lot of families between Beagle Bay. So Beagle Bay, Djarindjin/Lombadina, One Arm Point. Could be of course we do it locally, you know, to ourself here. But every now and then involve these other communities. And they'd love to see that too, they'd be saying the same thing, we wanna, you know, see these guys come. Cos whether it be sporting or just having this cultural thing, we can teach each other. Exchange, cultural exchange."
(Male, 32 years, One Arm Point)

9.3.2 Activities Coordination and Support

Question 5: *Who would be the best people/agencies to run the activities in the community?*

The majority of Study 2 participants reported that community-based activities for young people and families were best run by the community itself with outside agencies and groups supporting this process. Community-driven activities were seen to increase community responsibility and ownership, as well as reduce dependence

on outsiders, in order to achieve sustainability of the "Youth Project" over time. For example:

> *"And really you're putting responsibility back onto people in this community doing things for their community."* (Male, 43 years, One Arm Point)

> *"And people I think they've got to come from that community. Yeah. Just because again you want to look at sustaining that community, yeah. And getting them to control and own the issues and the solutions."*
> (Female, 43 years, Broome)

It was acknowledged that the community would need significant ongoing support to reach a point of initiating, developing and implementing activities. Strategies given by participants for coordinating and supporting activities to build strengths and promote youth and community wellbeing are discussed below.

9.3.2.1 Activities Coordinator

An overall coordinator of activities (some referred to this role as the recreation officer, youth worker) was viewed as essential to running community-based activities. Agency participants reflected that having a community member in this designated role would assist in collaboration with the community, engagement of young people and families with outside agencies and continuity of a youth intervention program. For example:

"They need more recreation officers put in place to run programs so there's ongoing programs. So it's contributing to their health and wellbeing."
(Female, 40 years, Broome)

Participants acknowledged that the recreation officer position had not worked well in the past and no-one had volunteered to take on this role for over 2 years. Participants believed that finding someone in the community to coordinate activities would be very challenging due to lack of incentive, poor motivation, difficulty managing feuding and criticism, and lack of support. Despite this, suggestions were given on how to improve the current model of delivering activities for young people and families in One Arm Point, summarised as follows:

- The coordinator needs to be from the community and based in the community.
- The position requires a new name as the person would be coordinating different types of activities, not just sport and recreation.
- The position needs to be full-time.
- The coordinator requires a real wage not CDEP.
- Given ongoing support, training and mentoring.

For example:

"I reckon they should have somebody from the community because I don't think people will be comfortable with having someone outside, you know

coming in and doing this, with their kids, you know. Better off somebody who's from the community." (Male, 21 years, One Arm Point)

"It's gotta be a paid position to make it worthwhile."
(Female, 47 years, One Arm Point)

"But offer the incentives. So then you know, the other community members go - he's getting all this because he's doing that, I wanna do that, you know. You've really gotta beef it up." (Male, 31 years, One Arm Point)

"So if you had a paid position that's working full-time and then we can complement them with training and we can show them how to do things. If they could recognise that and provide that position and then we can support that person whoever is doing it." (Male, 25 years, Broome)

Participants reported that the coordinator required the following qualities, knowledge and skills:

- Motivated to do the job.
- Experience organising and running activities.
- Experience with children and youth (including supervision, setting rules, limits).
- Not too overburdened with their own children.
- Ability to deal with criticism, jealousy and conflict.
- Well respected by community members.

- Have support from their family and other families.
- Be responsible for equipment and handling money (e.g., developing a system for this).
- Seek support from the Council and administration.
- Liaise with outside agencies and groups.
- Consult and report back to all community people, including advertising activities.
- Apply, manage and administer funding and report back to funding providers.

For example:

> *"They've gotta have someone with power. They've gotta have some sort of power base that they can supervise."* (Female, 47 years, One Arm Point)

> *"Oh just probably common knowledge around kids, you know. Like would know how to control kids from different families, you know. And people like probably would respect them, you know, have a lot of respect for that person."* (Male, 21 years, One Arm Point)

> *"And giving general feedback and everything, you know, if you let the community know what you're doing and all the information that you got to give out to the community, make sure, you know, that's done. And feedback to the community, talk to the community, just say, 'oh look, we just did this, next*

weekend it will be', you know, this type of stuff. Just communicating with each other basically, yeah." (Male, 32 years, One Arm Point)

Respondents commented that the coordinator needed a support structure, including:

- A team of people to assist the coordinator develop and run activities in each of the activity domains (e.g., sport and recreation, education and training, culture and so on). These people would take on specific activities to organise. They would require some sort of pay and incentives (e.g., training).
- A working party (committee) of volunteers to initially generate further ideas on types of activities, developing and running the activities. Encourage youth and parents to fulfil this role.
- An overall community development officer employed by Council and administration is needed to oversee all community projects, including the Youth Project.

For example:

"Ok, one idea that Beagle Bay did come up with and I must give them credit is after a lot of DCD stuff, they came up with this model of a community development officer, ok. To oversee all the little programs such as the child care, such as the 'Family Safety Project', such as the youth. One person to look after those little grants and provide the support, the training and

direction to those people who work in those positions and they only just little grants, but they look after the social side of things you know."

(Female, 43 years, Broome)

9.3.2.2 Community Support and Resources

Participants highlighted that in order for the Youth Project activities to be developed and run successfully, as well as maintained over time, ongoing support and resources from within and outside the community were needed. The engagement of young people and families in the interventions was contingent on support from the community.

Council and Administration

Firstly, support was required from the community Council and administration. Their role would not be to coordinate or develop youth activities. Rather, Council needed to show direction and leadership in supporting the Youth Project by making activities for young people and families a community priority. In a practical sense, Council needed to allocate funds (where available) to these activities, support the use of community vehicles and infrastructure for youth and family activities. Council and administration was required to work with the activities coordinator and support team to seek and administer funding. For example:

"Like having support by the Council as well. Support for getting more things, you know equipment and all that." (Male, 21 years, One Arm Point)

Community People

One Arm Point participants either nominated themselves or other community members to help with youth and family activities. Study respondents identified many people with knowledge and skills which could be made available to the Youth Project.

Those community people already working in the area of social and emotional wellbeing were seen as a valuable resource having relevant skills to assist with activities. For example, health workers and nurses could provide health and mental health information and link community members with outside agencies. School staff, particularly Aboriginal Education Liaison Officers (AELOs) had skills in organising school and community-based activities for young people and networking with families. AELOs reported that they had attended professional development workshops on community development, anger management, leadership and mentoring; information which they could disseminate to the rest of the community via the Youth Project. Thus, the school and clinic were cited as a potential resource for the Youth Project. However, it was also acknowledged that these service providers had limited time available outside their work commitments to play a large role in running youth activities. Additionally, wardens had provided supervision for discos and other events in the past and could do so for future recreation activities, for example:

> *"You can organise it (disco) but they need supervision, like – 'specially for the community one, you tend to get the young men come up and they've had a bit of booze, or the young girls and they start bitching with each other, you*

end up with a big fight. So you need the wardens there, if it's gonna be a community one, and you need a couple of adults there to help the young kids, otherwise the kids can't do it themselves."

(Female, 41 years, One Arm Point)

Elders were viewed as essential to oversee the development and implementation of cultural activities, and teach young people Bardi history and culture. The linking of older and younger community people was a goal shared by many community participants. It was recommended that Elders knowledgeable in language needed to spend more time in the school teaching children Bardi language and helping to run school-based cultural activities. Due to the reported "generation/culture gap" amongst some older and younger community members, middle generation men and women with cultural expertise were seen as necessary to assist by providing young people a link to older people. For example:

"You still would need a lot of old people to be involved. Not so much getting up and doing things, but just their knowledge, you know, passed on kind of thing. Make sure you go back and check with them and if you are going to start something up here, like whether it be taking the kids out and um cultural excursions out there or, you know or involved in something, you know. You would still have to go back to the old people and say 'hey, is this alright? Alright if we do this?' 'This place here, alright if we go there?' Um, they say yep or no you can't. So they are still supporting."

(Male, 32 years, One Arm Point)

Support from parents and carers was also reported as one of the most important aspects of the youth activities. Many participants believed that parental support for young people was lacking and parents taking an interest and helping with youth activities, such as discos and camps would increase supervision, support of children and connection to family. Some family members were identified as having particular skills in music or art which they could share with young people. For example:

> *"Just be a part of it. Be really good if they (parents) play a part in it sometime. Take a big part in it. Come along with their kids and see what their kids are doing, you know."* (Male, 26 years, One Arm Point)

Participants indicated that the involvement of young people in prioritising, developing and running community-based activities had potential benefits such as building skills, enhancing self-esteem, confidence, motivation and participation in activities.

It was highlighted that enlisting help from community people would be challenging due in part to lack of motivation, reliance on outside people to run activities, fighting and feuding amongst family groups. In addition, some community members had competing demands (e.g., work, family, crisis) and therefore could not offer as much assistance as others. It was also reported that many families or individuals focused on their own pursuits rather than on shared community goals, therefore may be reluctant to assist with community-based activities. Several suggestions were given to facilitate engagement of community people in supporting the Youth Project activities, summarised as follows:

- Start with small, achievable, popular activities.
- Enlist people already willing and confident to share their skills and knowledge.
- Engage small, like-minded, less formal groups already liaising (e.g., hatchery men, old girls, young mums, high school girls, boys).
- Engage already functioning formal groups (e.g., AELOs).
- Form women's and men's groups.
- Provide incentives.

Outside Agencies

It was reported in Study 2 that in order for the community to run and sustain the youth and family activities a considerable amount of ongoing support and resources were required from outside agencies and groups (e.g., Curtin University Project Team, Burdekin and Garnduwa). The community also needed to further build its links with outside agencies in order to seek the required support. Participants suggested that outside agencies would not run the activities, rather they would be an important part of the support structure surrounding the Youth Project and the activities coordinator. Direct support to the activities coordinator was seen as pivotal to provide support, training and mentoring in order to build skills and combat worker burn-out. Agency workers were viewed as an important resource to the Youth Project, in terms of sharing their knowledge and skills with community people as part of activities (e.g., information workshops, running camps and sporting events). Several agencies based in the Kimberley, mainly Broome were identified as potential support for the community in running the Youth Project. For example, those with particular expertise in health and mental health (e.g., KAMSC, Broome Regional

Aboriginal Medical Service (BRAMS), NWMHS, Kimberley Community Drug Service Team, Men's Outreach, Women's Refuge, DCD); sport and recreation (e.g., Garnduwa, Burdekin); education and training (e.g., TAFE, Notre Dame University; ATSIC/Indigenous Coordinating Centres); vocation (e.g., Kooljaman at Cape Leveque); and culture (e.g., Kimberley Aboriginal Law and Culture Centre (KALACC). It was acknowledged that some service providers were already overburdened with their work responsibilities and may find it hard to assist with community work.

Some examples:

> *"This is where we as government agencies come in and provide support there, to those people who are doing these things. Support and resources and training, you know."* (Female, 43 years, Broome)

> *"Because at the end of the day, how I see it, is that we will be working alongside of them to make it happen. We're not going to make it happen, we need to show them how to plan to do things. And have time, have reviews, so people can look back and see, 'Oh, how did this go?'"*
> (Female, 41 years, Broome)

> *"Yeah, say they're interested in silk screening then you get someone there for the whole week and hopefully when that person leaves, they should be able to keep going. You know, and then later on if there's a need to maybe add to*

that whatever you know they might wanna learn something else, that person if she wants to can be contracted to come out and do a bit more with 'em."

(Female, 41 years, One Arm Point)

Other Aboriginal communities were also perceived as a potential source of support and a resource for the Youth Project, for example, communities that had implemented solutions to tackle alcohol misuse. Community participants reported that they could visit other communities, exchange ideas, learn about these interventions and import knowledge back into the community.

In summary, the consensus among participants was that the Youth Project activities were best developed and run by the community, with outside agencies and groups supporting this process. There was a shift away from the previous model of one recreation officer providing sport and recreation activities for young people, as this person operated in virtual isolation with little training and support from within or outside the community and was prone to burn-out. The findings revealed that one overall activities coordinator was still required. However, this person would be directly assisted by a small team of people working together to develop and run activities. They would be linked into a network of support, expertise and resources consisting of the Council and administration, community development officer, key community people and outside agencies/groups.

9.3.3 Infrastructure

Participants were asked to nominate the physical spaces or settings they viewed as appropriate to carry out community-based activities.

Question 6: *Where would be the best place to run the activities?*

Several existing places and infrastructure were identified. Respondents conceded that young people needed their own space from which activities were run. The hall was identified as a suitable place for youth activities, for example:

> *"We've got that great big hall down there which is just sitting going to rot. It is a great venue. It's got loos, kitchens, stage, you could do whatever down there. It's not as if we haven't got the facility."*
> (Female, 47 years, One Arm Point)

It was suggested that sport and recreation activities could take place at the beach utilising existing beach volleyball nets and shaded area. Cultural activities, such as camps and day trips, could be run at Sunday Island, outstations and Kooljaman at Cape Leveque.

The One Arm Point School, particularly the school resource centre was nominated as a place of learning and training for adults and youth. Furthermore, the school was seen as a neutral place for parents to meet and discuss issues and attend skill-based workshops. Other participants believed activities, such as discos and DVD nights were best run outside the school. Some parents were reportedly less motivated to help and attend school-based activities where school staff was available to run activities. Activities run outside the school, in the hall or elsewhere, were more visible to community people and therefore encourage their attendance and support. Young people not attending school were thought to be reluctant to attend youth

activities based at the school and more likely to participate in activities outside school.

The women's centre (although requiring renovations) was seen as a space suitable for women's activities, mainly for older adolescent girls, parents and Elders, to do cultural activities, art and craft, listen to health and mental health information, learn skills, and generally function as a place for young women to reconnect with older women. Due to its less visible, more private location, the women's centre was deemed a good place for the general community to discuss and seek information on social and emotional issues. The women's centre was undergoing renovations which had taken some time, and required the completion of this work to make it a more usable space. Community participants reported that the "old shop" was also a place for running youth activities, although this too required completion of renovations.

Many participants reported their concern about the condition of some community infrastructure. In particular, the football oval and basketball courts were identified as needing urgent repair and maintenance, and the women's centre renovations needed to be finished. The hall also required cleaning up. For example:

> *"one of the major things probably that we could benefit from out here is getting the oval over here done up and hopefully that can be another stage from the 'Greening Project'. Um, total resurfacing of the area, planting and fencing off and reticulation."* (Male, 42 years, One Arm Point)

> *"they need more structured resources like a good court, basketball court, gym, ah proper light, proper undercover area because those things are needed so that kids can go somewhere without getting bored and staying around like their houses, if they wanna get into other substance misuse, all that sort of thing. They can actually use their energy into playing netball or basketball, or filling in their afternoon."* (Female, 40 years, Broome)

Overall, participants identified many operational places and spaces deemed appropriate for activities to occur and some which would be suitable with restoration and maintenance. Maintaining community infrastructure was viewed as an important but challenging part of starting and sustaining activities. Designated people were required to be responsible for the ongoing upkeep of community infrastructure in order for activities to occur consistently over time.

9.3.4 Activity Times

Question 7: *When would you run the activities?*

Community participants reported that there were particular times when young people had "nothing to do" and were subsequently prone to isolation, bullying, hanging around the school unsupervised, vandalising school property, wandering around the community causing "humbug", drinking alcohol, smoking gunja, fighting, and generally feeling bored. These vulnerable times were after school, nights, weekends, and school holidays. These were the times indicated by participants to run structured activities such as organised sport, recreation activities and camps for young people.

The consensus was that some sort of organised activities needed to happen most days after school (e.g., a youth drop-in-centre), some activities were required each weekend (e.g., sporting events) and some on a monthly basis (e.g., discos, camps). For example:

> *"I'd say we could work towards providing outdoor activity, after school, after hours. And perhaps we could get the community to focus on looking at that happening, and finding out that is providing good things for their youngsters instead of hearing problems where they've broken into buildings or things like that."* (Male, 30 years, One Arm Point)

> *"School holidays you could have things happening you know. You could work in with the community out there or here. You could take a group of kids camping, you know maybe work in with Middle Lagoon and ask them to you know, if they'll host a few kids out, let them camp out here for free or something."* (Female, 22 years, Broome)

There were also times and days reported to be more appropriate for running activities (e.g., meetings, information workshops) for parents and older people, such as Mondays to Wednesdays rather than later in the week "after pay day"; and mid morning or late afternoon rather than middle of the day. The general consensus from participants was that activities needed to be ongoing, not just "one offs".

9.4 Summary and Conclusion

Study 2 aimed to identify goals and methods for intervention to build strengths and promote the wellbeing of remote Aboriginal young people, their families and communities. A broad range of community-based activities were identified in the areas of sport and recreation, health and mental health, education and training, employment and culture. Sport and recreation activities and cultural activities were among the most popular activities nominated by participants. The findings indicated that the accepted approach to running Youth Project activities was community-driven, whereby the community design and implement activities with support from outside agencies and groups, and the whole of community is targeted as part of the youth and family activities.

Several recommendations were given to improve the previous model of providing youth activities in One Arm Point Community. The past model included one recreation officer organising activities with little support, training and resources. This person was prone to burn-out and the position had not been sustainable. The suggested model included a more organised structure of coordination and support, with an activities coordinator working alongside a small team of support personnel to help develop and run activities, and a working party, including young people to assist in prioritising and developing youth activities. The activities coordinator would also seek support from a community development officer, responsible for overseeing community projects, employed by Council/the community administration. The Council and administration were viewed as essential in providing leadership, support and releasing resources for the Youth Project. Existing knowledge and skills were

identified in many community people who could offer their expertise to the Youth Project. Additional expertise required to manage the project and deliver activities was seen to be available from outside agencies and groups, envisaged to be part of the support structure for the project and activities coordinator. Links with agencies and service providers outside the community needed to be strengthened and maintained as part of the goals of the Youth Project. Participants acknowledged that the community required significant and coordinated ongoing support, training and mentoring to meet the challenges of running the Youth Project and sustaining the activities into the future.

CHAPTER TEN

FINDINGS

STUDY 3: FEEDBACK AND VALIDATION OF THE RESEARCH FINDINGS

In Study 3 participants were asked to comment on a summarised version of the findings from Study 1 and 2. They were encouraged to provide feedback according to the accuracy, relevance and presentation of information, and to comment on the overall project and research process. Twelve groups consisting of 58 agency representatives from Broome and eight groups with 43 people from Ardyaloon Community, One Arm Point were conducted in Study 3. The feedback and validation comments reported in Chapter Ten are consolidated from Study 3 interviews, discussion groups and feedback forms filled out by participants at the time of their interview or mailed back to the author. The findings are outlined according to the feedback and validation questions and themes derived from the study. Information drawn directly from interview transcripts is cited to further exemplify the findings. Participants consented to this use of interview information at the time of interviews and discussion groups.

10.1 Validity

The main purpose of this study was to ascertain whether the findings accurately reflected what agency representatives and community people thought about the

mental health and social and emotional issues impacting on remote Aboriginal young people and families in the West Kimberley, and appropriate interventions to promote youth and community wellbeing. Respondents were asked the following:

Question 1: *What do you think of the summary information?*

Question 2: *Do you think the summary information is consistent with what you said in your interview or discussion group?*

Question 3: *Do you think the summary information is consistent with what you know about the social and emotional issues for young Aboriginal people and families living in remote communities?*

All respondents from Broome and One Arm Point reported that the information contained in the summary results accurately reflected their views and beliefs about the mental health and social and emotional wellbeing of remote Aboriginal children and youth. All participants involved in Study 1 and 2 stated that the information from their interviews interpreted and reported in the summary results was consistent with what they reported in Study 1 and or 2. For example:

> *"Everything that been put on this summary are exactly what has been happening in our community and we need to deal with them."*
> (One Arm Point written feedback)

"Yes would agree with the info being consistent with my experiences working with communities." (Broome written feedback)

"Very comprehensive, covers all the issues identified through our work with communities plus more." (Broome written feedback)

"Good. Identifies key issues, shows the complexity of issues Aboriginal people and communities deal with and how the issues are all related." (Broome written feedback)

"Yes and more. There are other issues raised that I was not aware of previously." (Broome written feedback)

10.2 Cultural Sensitivity

The findings were presented to participants in a summary format with lists of "plain language" information contained in several tables. Many study respondents, particularly Aboriginal people from Broome and Ardyaloon Community commented that this format, (presented in the context of an individual or group discussion) was preferred. The language was considered culturally sensitive and appropriate by Aboriginal participants. There were no requests to remove any of the research information contained in the summary results. For example:

"*very interesting and informative. I particularly like the summary into categories."* (One Arm Point written feedback)

"I think it was good because it's clear and easy to understand."

(One Arm Point written feedback)

"Mmm, it's very specific, isn't it? And I really thought it was really good um breaking it into, you know, at the individual level, then family and then community. Cos I think other things that I've seen are um, very general, a bit hard to know specifically what's been talked about."

(Broome feedback group)

10.3 Applicability

Qualitative research is interested in applicability of the information obtained to other situations and settings, rather than replication and generalisation (in a statistical sense). For example, "How is the study useful for other situations" (Rossman & Rallis, 1998, p. 47). Therefore, another goal of the feedback and validation study was to ascertain whether participants viewed the research findings as relevant, useful and applicable to their work in improving the wellbeing of Aboriginal young people and families living in remote communities in the West Kimberley. It must be cautioned that Indigenous peoples and their communities are unique, thus in applying the research findings to other situations and settings, this diversity must be respected and taken into account (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2000). For example, problems may be similar but prioritised differently; communities may have different ideas on intervention activities, although methods may be consistent.

Broome agency participants reported that the summary findings were useful for their work in remote Aboriginal communities. One Arm Point respondents reflected that the research findings were useful in their efforts to help young people. For example:

> *"The summary information is very informative and could be used well by relative agencies. It also gives a good description on what is and will be happening in our remote communities. Information can be used to better the way agencies all approach the communities."* (Broome written feedback)

> *"unhelpful ways of coping and positive ways of coping. I thought that was a really good way of looking at just practical ways that young people can deal with, you know, when they're feeling down, or if they're having problems and having a hard time. Like in friends, um you know, what to do, like take a deep breath and walk away, just little things like that I thought would be really easy to apply for workers and communities everywhere. Like cos, you know, sometimes you think, oh, what are you meant to do? Are you meant to fix it or how do you help that person manage that situation? But if it's really, it was so clearly outlined and just, you know, step by step things that you can do, even you know not giving other people drugs, grog or gunja. You know, that if they're feeling down and you think it might make them feel better, it's not really helping."* (Broome feedback group)

> *"It is clearly a document that can give direction and can be used by various government and non-government agencies, including the judiciary."*
> (Broome written feedback)

"I think that the summary had been written in a way that it made me realise that there is a lot of things we can do about it and teach each other, do more for one another." (One Arm Point written feedback)

"there's things there that I've read that need to make us change our approach, in how we approach the communities. I guess the way we've done it is mainly through the schools and that, and a bit through the community, but I think we need to make our approach more through the community rather than just through the schools, so that's one of the things that I could see in there that we haven't been doing." (Broome feedback group)

"Very comprehensive and applicable to many communities across the Kimberley with varying slight differences in emphasis."
(Broome written feedback)

10.4 Feedback and Validation of the Research Process

In addition to seeking validation on the research findings, the purpose of the feedback and validation study was to validate the research methods and process. The feedback and validation study was also a central part of the project methodology for maintaining trusting relationships and fostering engagement of local agencies and community people. Study 3 interviews and discussion groups provided the opportunity for continued discussion on community problems and solutions, in order to generate further interest from agency and community participants for their engagement in the next stage of the project – developing and running community-

based activities. Study 3 participants were asked to provide further information related to the research findings, comment on the project in general and the research process, as follows:

Question 4: *Do you have any more relevant information to add?*

Question 5: *Please add any final comments on the project, research process or summary information.*

Most respondents reported that the summary findings were comprehensive and they did not have anything to add directly to the summary results. Little new information was generated, however, participants did elaborate on the issues raised in Study 1 and 2. Discussing the research findings with participants, particularly community people, appeared to generate enthusiasm, motivation and a sense of ownership of tackling the problems identified. For example, with the summary results as a talking point, many participants spoke about ways they or other community members could help run youth and family activities (e.g., camps, teaching culture), ways of talking to young people about their difficulties, and combating problems (e.g., alcohol, fighting) at a community level.

For those who commented directly on the research process, the main theme highlighted was the researchers spending adequate time in the community. For example:

> *"the fact that you guys have gone out there and taken the time, because you want to get results, and it's shown here, because you've spent the time out there. You know, it's not just been a matter of, 'I've gotta get my results, let's go now' kind of thing. And the fact that you've come back and you've already started to do some of the activities that people'd like, you know the communities would have asked for."* (Broome feedback group)

> *"I think some of the agencies don't take the time to listen, whereas you guys have deliberately gone out and you know, sat at their level, you know, come to them and come to a place where they're comfortable, and have been willing to work around, you know, the issues that they wanna talk about, whereas, I reckon some of the other agencies probably aren't prepared to do that."* (Broome feedback group)

Other comments and suggestions included having more Aboriginal community people in the Project Advisory Group based in Broome, for example:

> *"Oh, I think you've done well enough for what you had when you started. Just getting everyone and the information here is fantastic so you're on a winner. I don't know how it could get any better um... [thinking]. Yeah, maybe if you had some community people in the team."*
> (Broome feedback group)

In addition, some Broome agency participants reported that researching problems experienced by young Aboriginal people in the West Kimberley was repetitive,

because they believed the issues were already covered in other research conducted in the area. For example:

> *"Done to death. Family stuff, we did a bit in 'True Words, Real Life', the 'death of loved ones', you know, 'alcohol and drug', breakdown, 'family fighting',' violence',' gambling', all those things. Ah, some of this community stuff came in the 'Choose Life' stuff, I suppose about um, you know, recreation stuff, CDEP, some kind of 'employment opportunities' and stuff like that. So in that sense, ah, I think it's consistent with what's already been recorded for the region."* (Broome feedback group)

Several participants requested information on what was to happen with the research findings. The overriding concern was that the project would continue and the activities identified would be carried out, at least in part. For example:

> *"Yes, one thing is that there is heaps of information and research done on the problems and social issues of Aboriginal people. But there isn't much done to promote the positive things."* (Broome written feedback)

> *"like the women's day that you had down there, fantastic!*
>
> *Yeah that was good.*
>
> *It brings everyone together*
>
> *And everybody was joking and thing.*
>
> *I don't think there's enough of 'em. There's not – there's really not enough.*
>
> *Well we should have more of that, all the womans getting together."*

(One Arm Point feedback group)

10.5 Conclusion

To conclude, the feedback from Study 3 confirmed the validity of the research findings and research process. The information contained in the summary results was found to be accurate, relevant and presented in a culturally safe manner. Additionally, many participants from agencies based in Broome perceived the findings as useful to their work in remote Aboriginal communities. One Arm Point respondents also found the information applicable to helping their young people with social and emotional problems.

SECTION FOUR:

DISCUSSION

AND

RECOMMENDATIONS

CHAPTER ELEVEN

DISCUSSION

More than a decade ago, Swan and Raphael (1995) expressed an urgent need to address the "crisis" in mental health in Aboriginal communities, including more research and interventions, especially for young people and families. The evidence on problems and related determinants of risk in Aboriginal young people has increased. Despite this, Aboriginal children and youth, particularly those living in remote communities continue to experience greater adversity, and vulnerability to mental health and social and emotional problems than non-Aboriginal youngsters (Hunter, 2007; Zubrick et al., 2005). Recent research has focused on resilience and strengths in Aboriginal people, although Hunter reports that overall the data on Aboriginal mental health and wellbeing is still poor. Furthermore, there is a lack of effective and sustainable interventions to combat the problems in remote Aboriginal communities. Consequently, the cycle of disadvantage and associated problems continues to have a detrimental impact on youth and community wellbeing (Gordon, Hallahan & Henry, 2002).

This final chapter presents a review and evaluation of the current research findings with reference to the relevant literature. Chapter Eleven also outlines the research limitations and suggestions for future research and intervention. The pertinent findings from the current research are synthesised with the literature into a model for mental health promotion intervention with remote young Aboriginal people, their families and communities.

11.1 Review and Evaluation of the Findings

11.1.1 Problems, Risk and Strengths

11.1.1.1 Social and Emotional Problems

The findings indicated extensive problems experienced by remote Aboriginal children and youth across social, emotional, educational and cultural spheres. The main social and emotional problems reported by participants in the current research were: alcohol and cannabis misuse; family fighting; lack of community-based activities, work and training opportunities, resulting in boredom; suicidal behaviour; and sexual abuse. Other significant social and emotional difficulties reported were: neglect, grief and loss related to the death of a close family member, education difficulties, breakdown and loss of culture, unemployment, lack of family and community support, juvenile crime, bullying, and gambling.

These findings are consistent with previous research and reports conducted in the Kimberley region and elsewhere (e.g., Gordon et al., 2002; Hunter, 1990, 1993; Kimberley Aboriginal Medical Services Council [KAMSC], 1999; Ralph, Hamaguchi & Murray, 2003). The types of education difficulties reported in the current study parallel those from previous reports, such as early school drop-out, poor school attendance and academic under-achievement (Aboriginal and Torres Strait Islander Commission [ATSIC: 1998]; Atkinson, Bridge & Gray, 1999; Trewin & Madden, 2005). In the current research it was reported that problems such as family fighting and violence, alcohol and drug misuse, suicide and sexual abuse had increased significantly over the last 20 years. This is consistent with Hunter's (1995)

report of increased suicide and family violence in Kimberley Aboriginal communities over the last two decades. Overall, there appears to be few changes in problems since these earlier studies.

11.1.1.2 Signs and Symptoms

Few studies have investigated directly the signs and symptoms of mental health and wellbeing problems in young Aboriginal people. In this research, participants reported that remote Aboriginal children and youth demonstrated that they had a problem by withdrawing, acting out or a combination of both. Young people experiencing significant distress displayed suicidal or self-harm behaviours. Girls reportedly showed more passive behaviours (e.g., internalising their distress), whereas young males were more likely to act out their difficulties via aggressive behaviour, usually after "bottling-up" their emotions for a time. Some participants indicated that they were unsure about what signs and symptoms to observe in remote young Aboriginal people experiencing social and emotional difficulties.

On the whole, the presentation of symptoms (e.g., thoughts, feelings and behaviours) reported in this research appears to be similar to those seen in non-Aboriginal youngsters experiencing mental health and social and emotional problems (e.g., Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision (DSM-IV-TR: American Psychiatric Association, 2000); International Statistical Classification of Disease and Related Health Problems (ICD-10: World Health Organisation, 2006). For example, young Aboriginal people in this research displayed withdrawal, negative perception of self and others, anxiety and anger. Variations were found in the language used by participants to report signs and

symptoms, such as talking “silly” (not making sense), “humbugs” (bothers) relatives a lot, and “shame” (intense shyness/lack of confidence). Sheldon (2005) reported that understanding language (Aboriginal languages and Aboriginal English or Kriol) is of utmost importance when assessing mental health problems in remote Aboriginal people. A small number of respondents in this research used cultural explanations in their reporting of signs and symptoms, for example feeling scared of being “sung”. In any conceptualisation of mental ill-health in Aboriginal people, the cultural context including culturally-based explanations underpinning thoughts, feelings and behaviours must be considered (Sheldon; Vicary & Westerman, 2004).

11.1.1.3 Coping Strategies

The current research identified both helpful and unhelpful coping strategies amongst remote young Aboriginal people, their families, friends, community and outside agencies. The predominant way for young people to deal with distress related to problems was alcohol and cannabis misuse. This included family or friends misusing substances and supplying the young person with alcohol and drugs when they had a problem. This coincides with Reser’s (1991) and Atkinson’s (2002) view that alcohol and drugs have been used by Aboriginal people to cope with suffering from past and current trauma. Overall, young people in the current research were perceived to possess few adaptive coping strategies to assist them manage boredom and distress.

11.1.1.4 Risk Factors

Risk factors or risk pathways are implicated in the development and maintenance of mental health and social and emotional problems in youngsters (Rutter, 1993). In the current research, problems and associated risk and protective factors were identified

at the individual youth, family, community, and societal levels (Zubrick et al., 2005). Participants reported a number of youth level issues, such as alcohol and cannabis misuse, low self-esteem and poor sense of self, education difficulties, unemployment, poor social skills, poor health and nutrition, death of loved ones, and isolation from family. This coincides with the Western Australian Aboriginal Child Health Survey (WAACHS: Zubrick et al., 2005) which reported that poor health and low self-esteem in Aboriginal children, excessive alcohol and cannabis use in Aboriginal adolescents, particularly females, contributed to heightened risk for emotional and social problems.

One of the most common familial risk factors reported in the present study was lack of family and community support for young people, which is consistent with the findings from the WAACHS study (Zubrick et al., 2005). The current findings also suggested that remote young Aboriginal people growing up in families experiencing drug and alcohol problems, fighting and violence, abuse and neglect, overcrowding, financial hardship, isolation from extended family, suicide or mental ill-health, were at greater risk for developing problems. This has also been exemplified in previous reports (Gordon et al., 2002). The WAACHS study found that higher household occupancy was a protective factor with more help available to the young Aboriginal person and stress being more dispersed (Zubrick et al.). However, the findings of the current research are consistent with those of other studies which have found that higher household occupancy contributing to overcrowding creates increasingly chaotic environments and increased problems for Aboriginal children and youth (Atkinson et al., 1999; Gordon et al). Social and economic disadvantage including unemployment, poverty and welfare dependence have been well cited as risk factors

for mental ill-health in Aboriginal populations (e.g., Pearson, 2000; Swan & Fagan, 1991), which is consistent with the present findings. In the WAACHS study, Zubrick et al. reported that risk factors such as stressful life events (e.g., death of relatives, separation) were indicated to be overwhelming families and increasing the risk for social and emotional problems in Aboriginal youngsters. In the present study, death of loved ones was also a commonly cited problem and reported to be a risk factor contributing to significant distress in remote young Aboriginal people.

Several community level risk factors were identified in the current study, such as lack of community recreation and cultural activities, work and training opportunities; the breakdown and loss of traditional culture; fighting amongst families; and lack of social and emotional wellbeing services and programs based in the community. The reported determinants of risk operating at the societal level included racism and discrimination, marginalisation from mainstream society, and the negative impact of historical policies and practices. Several previous reports and studies have also demonstrated that past government policies and practices have had a detrimental impact on the wellbeing of Aboriginal people (e.g., *The Bringing Them Home Report* (Human Rights and Equal Opportunity Commission [HREOC], 1997; Hunter, 1990, 1991b, 1991e, 1993; Zubrick et al., 2005).

Several social and emotional problems were highlighted by participants as being widespread in the community and contributing to the development of other problems at the youth, family and community level. These included the breakdown and loss of traditional culture, family fighting, alcohol and cannabis misuse, suicidal behaviour, and lack of community-based activities and opportunities.

Participants reported that alcohol and drug misuse and family fighting impacted on people's ability and motivation to teach and participate in cultural activities, resulting in further breakdown of culture, fragmentation of family connections and community structures (e.g., Council, women's and men's groups). As a result, the community had difficulty showing leadership and uniting to deal with community problems. The demise of traditional structures and processes, as well as lack of current ways to manage problems (e.g., lack of policing) was seen to contribute to ongoing violence and substance misuse in the community. This parallels Trudgen's (2000) and Memmott, Stacy, Chambers and Keys' (2001) finding that breakdown of socio-cultural and political systems for law, order and conflict resolution in communities are underlying factors in Aboriginal violence. Community governance problems and lack of policing have also been previously cited as contributing factors to ongoing violence and substance abuse in Aboriginal communities (Bolger, 1991; Gordon et al., 2002).

In the current project alcohol and drug misuse was seen to be a risk factor for fighting and violence, suicidal behaviour, abuse and neglect, unemployment, financial hardship, and school difficulties. Alcohol has been well cited as a precipitating factor in family and community violence (Atkinson, 1990, 2002; Bolger, 1991; Cheers et al., 2006; Hunter, 1991d, 1991e, 1993). Alcohol misuse (in the context of relationship conflict) was reported to contribute to suicidal behaviour in young adults, which is consistent with Hunter's (1991c) findings from his study of suicides in Kimberley Aboriginal populations.

In this research, family fighting was implicated by participants in the development of problems such as somatic complaints, depressive and anxiety symptoms, lack of engagement in activities (e.g., school, work), and isolation for remote young Aboriginal people. Fighting resulted in fragmentation of immediate and extended family connections, less shared activities and subsequently less overall support for children and youth. In research focusing on violence in other Aboriginal communities, Cheers et al. (2006) reported that community people believed violence eroded family and community cohesion, Elder authority, and reduced social supports, findings which are supported by this research.

Participants reported that the lack of community-based activities and lack of youth engagement in available structured activities (e.g., school, work or study) made youth vulnerable to other problems. For example, young people experienced extreme boredom from having few activities. Respondents noted that early school drop-out resulted in inadequate reading and writing skills; unemployment and low educational achievement resulted in low self-esteem and lack of skills. Lack of educational, vocational, social and life skills were believed to contribute to difficulty accessing opportunities outside the community, leading to further marginalisation from the wider society. Similarly, Hunter (1993) reported that poor school attendance has significant impact on youth wellbeing, contributing to decreased skills and social supports, and marginalisation from mainstream society. In this research, young women who dropped out of school prematurely were reported to experience teenage pregnancy and relationship issues. Young men and women not attending school, work or study were seen as increasingly likely to engage in juvenile crime, alcohol

and or cannabis misuse, fighting, and to experience peer pressure, hopelessness and have a negative view of the future.

This research indicated that many remote Aboriginal participants had been directly affected by suicide, including suicidal behaviour in young people. In the present study, the precipitating/risk factors reported by respondents to contribute to suicidal behaviour were similar to those reported in previous studies, such as relationship conflict, excessive alcohol use, histories of abuse and neglect, family violence, depression, hopelessness, social isolation, perceived rejection and lack of adaptive coping skills (Hunter, Reser, Baird & Reser, 1999; KAMSC, 1999; Kyaw, 1993; Westerman, 2003; Westerman & Vicary, 2000). The current findings also indicated that guilt and shame related to sibling sexual abuse; sexual identity issues related to sexual abuse; trauma, grief and loss associated with the death(s) of loved ones, particularly deaths from suicide; and lack of support and counselling contributed to suicidal behaviour. In the current research, the impact of suicide was reportedly extremely distressing with remote Aboriginal people experiencing trauma symptoms such as anger, depression, anxiety, alcohol and drug misuse, and suicidal behaviour. This validates Ralph et al.'s (2003) findings that Kimberley Aboriginal respondents (predominantly youth) evidenced symptoms of posttraumatic stress disorder (PTSD), depression, anxiety and suicidal ideation.

11.1.1.5 Resilience and Protective Factors

The problems experienced by Aboriginal youngsters, and the associated risks are increasingly well documented, however there is less research evidence pertaining to those factors protecting young Aboriginal people from experiencing more serious

social and emotional problems. Protective or resilience factors reduce the likelihood of developing mental health and social and emotional problems, by reducing one's exposure to risk or moderating the impact of risk factors (Spence, 1996). The current project identified local definitions of wellbeing and resilience, as well as factors operating at various levels (e.g., youth, family, community, society) reported to provide a buffer against mental ill-health and wellbeing problems, and build strengths in remote young Aboriginal people.

In this research, remote Aboriginal youth wellbeing was perceived holistically and embraced interconnecting influences such as health, emotional, social, cultural, spiritual, economic and historical factors, across the individual, family and community. This parallels reports detailing Aboriginal conceptions of mental health which espouse a holistic view of mental health and wellbeing, where the person is positioned within the wider context of family, community and society, and individual wellbeing is contingent on the wellbeing of the whole community (Swan & Raphael, 1995).

Participants reported that a remote young Aboriginal person with good wellbeing/*liyan* would have good physical and mental health, be generally happy, socialising with family and peers, engaged in education, employment or study, and not involved in fighting and alcohol and drug misuse. The young person would be independent, responsible, looking after themself and their family. The individual would have a strong sense of self and belonging to family, community and country.

In this research, a remote young Aboriginal person considered resilient or strong was identified by respondents as having the ability to overcome their difficulties and live a positive life, have positive self-esteem and pride, use adaptive coping strategies, do well in education and vocation, and engage in sporting and recreation activities. A strong young person was also seen to have cultural knowledge and practise culture; show respect to self and others; have strong connection to family and peers; have good social and life skills (e.g., managing finances) allowing them the ability to navigate well in community/cultural and mainstream life; have future goals and motivation; and be a positive role model to others.

These definitions include individual youth level protective factors cited by participants in the current research. Protective or resilience factors identified at the family level included support from parents, carers and extended family. At the community level protective factors included: living in a cohesive, supportive community, and having recreation activities, work and training opportunities based in the community. Respondents noted that providing young people with recreation activities would divert them from antisocial behaviour, reduce boredom and social isolation, increase adult supervision, peer support, pro-social skills and self-esteem. In the current study, protective factors at the societal level included increased cultural awareness, adequately resourced and culturally sensitive programs and services, access to equal opportunities and inclusion in mainstream society.

Culture was viewed by many participants as a resilience factor in young people, their families and the community. Despite the problems reported by participants, culture was perceived as relatively strong in some families and the community. Culture was

seen as a vehicle for building individual and community self-esteem, pride and strong identity. Participants believed that children and youth engaged in cultural activities with families and peers received increased support and guidance, and were less isolated. Participants reported that families coming together to practise culture enhanced community connectedness and extended family support. Participating in cultural activities was viewed as a deterrent from alcohol, drugs, violence, and boredom. In contrast, Zubrick et al. (2005) investigated the impact of maternal participation in cultural activities and did not find this protected young people from experiencing social and emotional problems. Zubrick et al. suggest that other risk factors, such as multiple life stressors, may have mitigated the overall positive influence of culture. Other studies have found knowledge and practise of culture a significant protective factor in promoting social and emotional wellbeing in Aboriginal people and communities (e.g., Cheers et al., 2006; McLennan & Khavarpour, 2004). Westerman (2003) reported that young people in the Northwest of WA who were affiliated with their culture and knew their Indigenous language evidenced fewer symptoms for depression, anxiety and suicidal ideation. The current research shows strong support for the findings from previous studies which suggest engagement in cultural activities and affiliation with culture enhance the wellbeing of Aboriginal young people, families and communities.

In summary, the current research findings suggest that to build strengths and promote the wellbeing of remote Aboriginal children and youth, particularly those young people at One Arm Point, it is necessary to increase connectedness of young people, families and the community to increase supports and decrease fighting and fragmentation; improve engagement in structured activities to relieve boredom, build

skills and divert youth from antisocial behaviour, including substance misuse; promote cultural values, knowledge and practices; enhance community leadership and management; and increase resources and skills in the community and outside agencies to provide community-based support and counselling.

11.1.2 Community Solutions

The second aim of this research was to identify and describe culturally sensitive ways of promoting wellbeing and building strengths in young Aboriginal people and their families living in remote communities in the West Kimberley.

11.1.2.1 Problems with Agency and Community Activities

Study 2 included identifying the perceived problems with existing agency and community mental health and wellbeing services for remote young Aboriginal people and families. Participants reported that the main problems associated with agencies were: lack of response, inappropriate response, lack of relationship building with the community, and lack of resources to meet the demand for community-based support, counselling and preventative intervention.

These findings are consistent with past reports. For example, the *Kimberley Regional Aboriginal Health Plan* (Atkinson et al., 1999) and the *Kimberley Regional Aboriginal Mental Health Plan* (KAMSC & Westerman, 2002) reported a lack of resources directed at social and emotional services and programs in remote Aboriginal communities in the Kimberley. The current findings imply a continued unmet need for substantially greater funds and resources to address the mental health and social and emotional problems in Kimberley Aboriginal communities.

The main problems reported for community-based activities were: lack of support from the Council/administration and families; lack of resources (e.g., funds, vehicles, people); and poorly maintained equipment and infrastructure. The recreation officer position had remained unfilled due to lack of incentive, support, training, and difficulty managing feuding and criticism. Gordon et al. (2002) also found that workers in remote areas are unsupported and prone to burn-out.

11.1.2.2 Types of Community-based Activities

In the current research the types of activities identified as likely to be useful for promoting youth wellbeing were broad-based, in five main areas: sport and recreation; health and mental health; education and training; employment; and culture.

Participants reported that popular sport and recreation activities included organised sporting teams and competitions (e.g., football, basketball), youth drop-in-centre, DVD nights and discos. In relation to health and mental health activities, the findings indicated that remote community people wanted more practical information on nutrition, sexual health, pregnancy and parenting, smoking, alcohol and drug prevention. Respondents wanted more support and counselling for relationship issues, conflict, suicide, sexual abuse, grief and loss. Participants identified a strong need for a counsellor based in the community and requested that community people be trained in recognising signs and symptoms, talking to youth who are experiencing problems, and problem solving strategies to assist young people. The findings revealed a need for community-level strategies to manage problems such as fighting, drug and alcohol issues, gambling/neglect and child sexual abuse.

Education and training initiatives suggested by participants in this research included, developing a local high school, making the curriculum more culturally appropriate and comparable to mainstream schooling, and developing an adult education centre in the community offering skills-based vocational training. It was also found that training was needed at the community level in the areas of leadership, governance, community management, workforce and project development.

Participants reported several activities designed to promote employment in the community in order to generate income for individuals and the community. These initiatives included, re-evaluating CDEP and paying community service providers (e.g., wardens) real wages. Atkinson et al. (1999) and KAMSC (1999) reported the limitations of CDEP and need for more substantial training and employment options for Kimberley Aboriginal people. Similarly, in this research participants saw a huge need for vocational opportunities such as work experience and small business (e.g., tourism) instead of reliance on CDEP or welfare.

In relation to culture, it was recognised by participants that cultural activities needed to be more widely shared amongst all young people and families to promote youth and community wellbeing. It was reported that this could take place through community gatherings and bush trips, spending time with Elders and practising Law. The findings also illustrated that preserving traditional culture was important and the suggested activities for this included having a community culture centre, and recording language and old people's stories/knowledge.

11.1.2.3 Running Community-based Activities

The findings indicated that developing and implementing intervention activities to build strengths and promote the wellbeing of remote Aboriginal youth needed to focus on the whole community, with some activities targeted at individual groups (e.g., youth disengaged from school and work), and some activities involving neighbouring communities. Brown, Hunter and Whiteside (2002) also explained that intervention focusing on the entire community is essential in Aboriginal contexts to improve wellbeing.

The current research revealed that community-based activities needed to be prioritised and developed by the community, with support and resources from outside agencies and groups. With the community directing this process, it was indicated that the community would be better placed to assume ownership and responsibility for running the activities, it would rely less on outsiders to deal with community problems and run activities, therefore the youth activities were more likely to be sustained into the future. Community-directed intervention to improve mental health and wellbeing in Aboriginal communities has been well supported in the intervention literature. For example, Mitchell (2000) reported a decline in the suicide rate in Yarrabah Community, Cape York in Far North Queensland, following community-driven, community development initiatives supported by outsiders.

The research respondents indicated a shift away from having one recreation officer running activities as this had failed in the past. The research identified that one overall (activities) coordinator was still needed. However, the coordinator required: a real wage, not CDEP; to possess the necessary qualities and skills; and to receive

adequate training and support via a support structure/network consisting of community and agency representatives.

The current research found that while the community viewed itself as central in developing intervention activities, they believed they could not do this, at least in the short to medium-term, without support and resources from outside agencies and groups. Participants reported that these agencies and groups could offer initial assistance in coordination and facilitation, ongoing training, as well as workers to assist with activities, funding, equipment and infrastructure. This is consistent with Pearson's (2000) assertion that Aboriginal people and communities require access to resources and skills in order to become empowered and assume ownership and responsibility for improving wellbeing. It was also noted in the current research that the community could offer localised knowledge and skills to outside agencies and groups improving the cultural competence of service providers and delivery of social and emotional wellbeing services to remote communities.

11.2 Review and Evaluation of the Methodology

11.2.1 Approach and Methods

The overarching goal of this project was to work with agency and community representatives in empowering ways, to encourage local involvement, ownership and direction in identifying problems and finding solutions to enhance the wellbeing of remote Aboriginal young people, their families and communities (Pearson, 2000; Smith, 1999, 2005; Swan & Raphael, 1995). This included building capacity in agencies and community people for implementing solutions and sustaining these

solutions into the future (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2000, Pearson, 2003).

The qualitative approach employed in this research embedded the research and researchers in the cultural context, at the community level (Bishop, 2005; Sonn & Bishop, 2000). In this approach research information was gathered and knowledge developed in an iterative-generative-reflective process that encouraged community participation, ownership and direction of the research project (Bishop, Sonn, Drew & Contos, 2002). The author (Project Coordinator) facilitated this process, with aims, methods and outcomes driven by agency and community people (Patton, 2002; Smith, 1999). The approach was designed to ensure the research was meaningful, relevant, culturally sensitive and of overall benefit to the local Aboriginal people and communities involved (National Health and Medical Research Council [NHMRC], 2003). The approach was flexible enough to make modifications and to allow the research to emerge as part of the research process, allowing opportunities for empowerment and social change (Rappaport, 1994; Rossman & Rallis, 1998; Taylor & Bogdan, 1998). For example, the project embraced local agency and community priorities of needing practical solutions to address youth and community problems. As a result, the research identified and described goals and methods for intervention to promote the wellbeing of remote Aboriginal young people, and worked with agencies and the community to lay the foundations for implementing community-derived mental health promotion interventions.

The support from Broome-based agencies and continued involvement of agency and community people in the project confirmed the acceptability of the approach and

methods, aims and outcomes to local agency service providers and remote Aboriginal people. The feedback from Study 3: *Feedback and Validation of the Research Findings* also confirmed the acceptance and validity of the approach and methods by local Aboriginal and non-Aboriginal people involved in the project. The approach and methods employed in the current research were an overall strength of the project, in terms of achieving the outcomes set out by local agencies and remote community people.

11.2.2 Limitations and Challenges of the Research

Research with Aboriginal people and communities is best conducted by Aboriginal people (Smith, 1999). This research was coordinated by a non-Aboriginal person, with the goal of building capacity in the Aboriginal community for the community to assume responsibility and ownership of running the project. Employing local Aboriginal people was a key objective of this project, however this presented several challenges. Local Aboriginal people skilled in mental health research and intervention were already over-burdened with the workloads they had. There was a shortage of local people, particularly in remote communities with skills in research and intervention. Many community people had vital knowledge and skills to contribute, although lacked motivation and confidence, had competing family and community demands, or were overwhelmed with existing problems. Therefore, considerable time was needed to build trusting relationships, to foster engagement and build capacity of community people. Employing several people on a casual basis, and working collaboratively with agency service providers (e.g., youth workers) proved viable ways to build up a pool of people to work on various aspects of the project (e.g., field trips, data collection, transcribing). Project workers required

ongoing support, mentoring and training, at times related to challenges working closely with related families/communities. Overall, building capacity in the community was needed prior to the community assuming coordination of the project and this was factored into the goals and methods of this research.

The Aboriginal Project Advisory Group based in Broome was made up of Broome-based service providers. This group would have benefited from having the direct input of community people on devising research questions and methods. This was logistically difficult as community people lived 3 hrs away. To overcome this, the project team attempted to feed back and validate Project Advisory Group information with community reference people to ensure ongoing input from the community.

Considerable time is needed in community-directed intervention research to build trusting relationships, particularly given the experience of mistrust in Aboriginal communities toward non-Aboriginal outsiders. It is a limitation that usually when trust is built the outside project worker(s) leave or the project comes to an end. Mental health and wellbeing research and intervention needs to be well resourced and planned with short, medium and long-term goals and outcomes to allow for adequate time to build and maintain relationships/partnerships, to facilitate capacity building and longer term sustainability of interventions. Agencies and institutions, including funding providers need to shift their focus to incorporate these goals.

11.3 A Proposed Model to Promote Remote Aboriginal Youth Wellbeing

11.3.1 Rationale and Approach

The following synthesises key findings from the current research with the literature pertaining to Aboriginal mental health and wellbeing problems and intervention, to propose a model for mental health promotion intervention with remote Aboriginal young people and communities. In order to improve the mental health and wellbeing of remote Aboriginal children and youth, adequately resourced, effective and culturally appropriate intervention is required (Hunter, 2007; Swan & Raphael, 1995). The notion of empowerment needs to underlie any framework for intervention because Aboriginal empowerment through participation, control and ownership of intervention priorities, methods and outcomes are central to the efficacy and sustainability of interventions, and improving the wellbeing of Aboriginal people and communities (Eckermann et al., 2006; Kirmayer, Simpson & Cargo, 2003; Rappaport, 1994). For Aboriginal people to be self-determining in improving their mental health and wellbeing, they require sufficient capacity to assume responsibility and take control to facilitate change (Pearson, 2000; Tann, 2002). Building capacity, such as knowledge, skills, resources, employment, and developing existing capacity must be overarching goals of mental health promotion intervention with remote Aboriginal communities (Commonwealth Department of Health and Aged Care [CDHAC], 2000; Maton, 2005; Pearson).

Mental health promotion intervention needs to encompass a holistic view of Aboriginal mental health and wellbeing, which accounts for socio-historic, cultural factors and emphasises wellness and strengths (Swan & Raphael, 1995). This

includes a focus on the interrelatedness of problems and associated risk and resilience factors which operate at varying levels of influence to impact on individual and community wellbeing (Cheers et al., 2006; Durlak, 2000). Broad-based intervention operating in several areas targeting different levels in the community is required to address interconnecting problems and contributing factors, and build strengths in remote young Aboriginal people, families and communities (Brown, Hunter & Whiteside, 2002; Cheers et al., 2006; Mitchell, 2000). For example, in the current research a broad range of intervention activities were identified in several areas (e.g., sport and recreation, health and mental health), at various levels (e.g., youth, families, community, outside agencies). Activities aimed to build strengths such as connection to family and community through sharing cultural activities; skills in mental health awareness and parenting, education and vocation, community administration and management; and resources to provide support and counselling in the community.

It is recommended that a community development approach be used to promote mental health and wellbeing in remote Aboriginal young people, families and communities (Tann, 2002). Within this approach intervention needs to be embedded in the cultural and social context of the community, where goals, methods and outcomes are community-driven and emerge from the context rather than outsiders (Rappaport, 1994; Smith, 1999; Trickett & Birman, 2000). In the current research (and related research/projects) the accepted role of outsiders was to assist (not direct) the community in coordination of the project, which included facilitating community engagement, skills and resource acquisition, so the community could build the capacity to take responsibility, ownership and management of the project (AIATSIS,

2000). This occurred in the context of trusting relationships and equal partnerships between the researchers (outsiders) and agencies and the community (NHMRC, 2003).

11.3.2 Goals, Methods and Outcomes

The following mental health promotion intervention model outlines proposed goals, methods and outcomes for intervention, occurring in three stages: (1) *Consultation to Community Engagement*; (2) *Community Management of the Intervention*; and (3) *Sustaining the Intervention*. The goals and outcomes aim to provide a general direction for intervention, however will need to be tailored according to specific community priorities and needs. In this model, the short-term goals of mental health promotion intervention are for the community to identify mental health and social and emotional problems impacting on remote Aboriginal children and youth, and to identify solutions to build strengths and promote youth and community wellbeing. The medium to long-term goals are that the community develops and runs the intervention activities and that intervention processes and activities are sustained into the future. The model is presented in discrete stages, however in applying the methodology in a remote community setting it must be noted that processes will overlap and some will be ongoing throughout the intervention. Timeframes will also depend on the context, although it is recommended that intervention projects in remote Aboriginal communities plan to be long-term.

Stage 1: *Consultation to Community Engagement*

Goals

The main goal of Stage 1 is for the community and agencies to identify problems and strengths impacting on youth and community wellbeing, and identify solutions for tackling problems, building strengths and promoting wellbeing. An overarching goal is to build community and agency capacity (e.g., motivation, knowledge, skills and resources) for the community to take ownership and manage the intervention which involves prioritising problems and solutions, and developing, implementing and evaluating community derived solutions.

Methods

It is recommended that to achieve Stage 1 goals the community is assisted by outsiders (where needed) to coordinate and facilitate the intervention. Outsiders will consult widely with agency and community representatives, in order to understand issues from a local perspective, and learn the local history and culture to work in culturally sensitive ways with agencies and the community (Smith, 2005; Trudgen, 2004). Outsiders will endeavour to build trusting relationships and collaborative partnerships with agencies and the community. It is advocated that a network of advisors be operationalised to direct the intervention project, including an Aboriginal-directed Project Advisory Group and community reference people (Bishop, Vicary, Andrews & Pearson, 2006; Westerman, 2003). Outsiders will work with existing Aboriginal structures to form ethics and collaborative agreements at community (council/Elders), local (Aboriginal community controlled health service), and State (Aboriginal ethics committee) levels in order to promote the leadership and

management of these groups (AIATSIS, 2000; NHMRC, 2003). Local Aboriginal people will be employed and trained to work on the project. Collaborative work, including training project assistants will be characterised by an exchange of knowledge and skills between outsiders and local people (Social Health Reference Group, 2004). It will be necessary to assess what stage the community is at in terms of tackling youth and community problems and to scope existing resources (e.g., people, knowledge, skills, funds and infrastructure) needed for the community to prioritise, develop and implement interventions (AIATSIS, 2000; Pearson, 2000). This may involve providing training to the community in seeking and administering funding and other resources.

Evaluation

The aim of evaluation in Stage 1 is to collect information from agencies and community representatives on problems and strengths impacting on youth and community wellbeing, and strategies for building strengths and promoting the wellbeing of young people, their families and the community. A further goal is to ascertain the level of community and agency engagement in the intervention project. The community and outsiders will work collaboratively to devise evaluation tools and methods. Outsiders will assist in employment and training of local people to conduct the evaluation. It is recommended that two (or more) rounds of interviews and or discussion groups be conducted with agency service providers and community representatives to explore problems and solutions, and facilitate engagement in this process. Information will be fed back to the participating agencies and community, and they will formally validate the findings and methods (Hunter, 1992b). Evaluation throughout the intervention will also involve participant observation, including

taking detailed field notes to report on contextual/indicators of change (e.g., community involvement, increased skills).

Outcomes

The proposed outcomes of Stage 1 are that the community and agencies engage in identifying and exploring problems and solutions, initiating their resolve to tackle youth and community problems, with the community council and Elders showing support and leadership in this process. Community relationships with outside groups and agencies are strengthened; knowledge and skills are exchanged in the context of these partnerships. As a result, the community has increased access to resources (e.g., skills, funding, workers), and outsiders improve the way they work with the community. A pool of people are mobilised and up skilled to work on the project, and the community secures funding for the continuation of the intervention.

Stage 2: *Community Management of the Intervention*

Goals

The main goal of Stage 2 is that the community takes ownership and management of the intervention project with the support from outside agencies and groups. For example, the community develops, implements and evaluates initial intervention activities. Outsiders continue to assist in building community capacity to run the intervention.

Methods

To achieve the goal of Stage 2, it is recommended that a coordinator based in the community be employed (if a local person is not already in this role) and outsiders hand over project coordination to the community-based coordinator. In this stage, the support structure for the coordinator will be formalised and maintained. The support structure will consist of outsiders already involved with the community/project; the community council and administration staff (e.g., community development officer); project assistants; working party of youth, parents, Elders, and other helpers. The coordinator and team will work with young people, families and existing community groups to increase assistance with and participation in the activities. The community will maintain networks with outside agencies and groups and seek required resources and support for running intervention activities. Outsiders will continue to maintain relationships/partnerships with the community and provide support, mentoring and training where needed.

Evaluation

The aim of Stage 2 evaluation is to determine the impact, effectiveness and acceptability of intervention activities in terms of building youth and community strengths and improving wellbeing. A further goal is to determine the level of community engagement and ownership of running the project. Evaluation tools and methods (e.g., interview schedules) will be developed by the community with assistance from outsiders. Mikhailovich, Morrison and Arebena (2007) recommend a mixed method approach in evaluation of health promotion interventions, incorporating qualitative, quantitative and other methods (e.g., video evidence). Outsiders will train and mentor community project workers to conduct the

evaluation. The community will feed back and validate the findings with community and agency representatives, allowing for reflection and continued development and refinement of activities and methods (Bishop et al., 2002).

Outcomes

The outcomes of Stage 2 are that the community assumes ownership and management of the intervention project. Some of the intervention activities are implemented and activities are accepted by the community. Activities show a positive impact on youth and community wellbeing, building strengths and demonstrating an initial reduction of problems and associated risk. The community's relationships with outside agencies and groups are enhanced. The community seeks resources from within and outside the community to assist with the project. This includes applying for funding and administering funding. Outside agencies and groups improve their way of working with the remote Aboriginal community.

Stage 3: *Sustaining the Intervention*

Goals

The goal of Stage 3 is that the community continues to manage youth and community problems: identify problems and develop, implement and evaluate solutions/interventions over time.

Methods

To fulfil this goal, the coordinator/community is required to identify and seek resources from within the community (e.g., council, school, Elders, parents, youth)

and outside agencies and groups (e.g., support, mentoring, training, funding). This may include assistance with training project workers, or evaluation. The coordinator/ community and outsiders need to maintain their partnerships, for the community to continue to increase its capacity to tackle its own problems.

Evaluation

The goals of Stage 3 evaluation are to determine the impact, effectiveness, and acceptability of intervention activities in terms of building youth and community strengths and improving wellbeing. Additionally, to determine the level of continued community engagement, capacity building and overall sustainability of the intervention methods (e.g., coordination and support structure, seeking resources and onging funding). To achieve these goals, the community will refine and further develop the evaluation tools and methods. The community will employ and train project workers to conduct evaluation, seeking outside support where needed.

Outcomes

The outcomes of Stage 3 are that community members are skilled in community-based mental health promotion intervention and generalising methods to identify problems and carry out solutions over time. The community sustains methods for tackling youth and community problems. Young people, families and the community have increased strengths (e.g., awareness, skills, connectedness, support) providing a buffer against problems. The social and emotional problems and associated risk factors identified by the community and agencies are reduced.

11.4 Dissemination and Application of the Findings

The research findings were widely disseminated amongst those involved in the project and additional agency and community people interested in the research. Feedback of research information occurred as an ongoing part of the project through informal discussions, meetings, progress reports and in formalised discussion groups (Study 3). The findings were perceived to be acceptable, accurate, useful, and presented in a culturally sensitive manner. Participants involved in validation of the research findings conceded that the results reflected their understanding and experience of West Kimberley young Aboriginal people, families and communities. However, it must be cautioned that in applying these findings to other Aboriginal populations, it is essential to respect the diversity and heterogeneity of different groups (AIATSIS, 2000). Therefore, it is pivotal to take direction from communities or groups, in prioritising research goals, methods and proposed outcomes.

A major concern of people involved in this research was that the project would continue and some of the solutions derived by Broome and One Arm Point Community participants be carried out. The current research was part of a larger project, therefore the findings from this research informed the next stage of the overall project.

From 2004, Ardyaloon Community in partnership with the Curtin University Project Team developed the "*Baawa Ingul Gooron*: Bardi Youth Project". Some of the intervention activities prioritised by the community in Stage 1 (the current research) were developed and implemented. Evaluation strategies were developed with the

community and the activities evaluated as part of the Youth Project. In 2005, the community secured ongoing funding (2006-2007) from Healthway WA, which enabled the community to run the project independently, assuming ownership and control while seeking outside mentoring and support where and when it was needed.

11.5 Future Directions for Aboriginal Mental Health Research and Intervention

It is a limitation of Aboriginal mental health promotion in general that interventions in Aboriginal communities are rarely evaluated and evaluation methods are inadequate and not well described, thus there is little systematic research on the efficacy of interventions (Gordon et al., 2002). Goals, methods and outcomes for evaluating interventions need to be integral to the design of intervention research. Evaluation needs to be directed by the community and the community may require training and support to conduct efficacy studies (Tsey, 2000). Evaluation of interventions prioritised by communities themselves will assist in acquiring support and funding for implementing solutions deemed culturally relevant and effective by Aboriginal people and communities, as opposed to those seen as beneficial by mainstream providers.

There is a growing evidence-base of the impact of trauma on mental health and wellbeing in the general population, however a paucity of information related to Aboriginal people and communities. Given the high rate of problems and associated distress reported in the literature, and in the current research, future research in the area of trauma would be of benefit. It is suggested that research focus on

understanding the prevalence, aetiology and impact of trauma on the mental health and social and emotional wellbeing of Aboriginal youngsters, and to extend existing research and reports on intergenerational effects of trauma (e.g., Atkinson, 2002; Gordon et al., 2002). These research efforts will further guide mental health interventions with young Aboriginal people, families and communities.

11.6 Summary and Conclusion

The findings aimed to extend the current knowledge on the social and emotional wellbeing of remote Aboriginal children and youth, and present culturally sensitive and sustainable intervention goals and methods to improve youth and community wellbeing. Insight has been provided on the main problems, risk and resilience factors, as well as symptomatology and coping strategies seen in remote young people, families and communities. Problems have been presented holistically and contextually with consideration of the broad range of interconnecting influences (e.g., social, historical, cultural factors) operating at a number of levels (e.g., youth, family, community, outside agencies, society) (Cheers et al., 2006).

The current research aimed to work at the community level, in trusting partnerships with Broome-based agencies and Ardyaloon Community. As a result, problems and intervention strategies were derived by the agencies and community, having direct relevance and benefit to those involved. The project aimed to facilitate local engagement and capacity building. Consequently, agency representatives and the community acquired and sustained knowledge and skills for tackling youth and community problems, and the researchers learned more effective and culturally

acceptable ways of working with local agencies and remote Aboriginal communities. A model for mental health promotion intervention based on this and related research has been presented to guide future intervention efforts with young Aboriginal people living in remote communities. There are still huge challenges facing Aboriginal communities, especially those in remote areas in terms of engagement, building capacity and attaining resources to sustain community-based interventions. The effort to combat mental health and social and emotional problems, and promote strengths in remote Aboriginal children and youth requires community-directed action with ongoing support, long-term planning and adequate funding for intervention activities to have any chance of success in improving the lives of remote Aboriginal young people, their families and communities.

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GLOSSARY OF ABBREVIATIONS

ACCHSs	Aboriginal Community Controlled Health Services
AELOs	Aboriginal Educational Liaison Officers
AHWs	Aboriginal Health Workers
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AMHWs	Aboriginal Mental Health Workers
AMSs	Aboriginal Medical Services
ATSIC	Aboriginal and Torres Strait Islander Commission
BRACS	Broadcasting for Remote Aboriginal Communities Scheme
BRAMS	Broome Regional Aboriginal Medical Service
CDEP	Community Development Employment Projects
CDHAC	Commonwealth Department of Health and Aged Care
CYP	Cape York Partnerships
DCD	Department for Community Development
HREOC	Human Rights and Equal Opportunity Commission
KALACC	Kimberley Aboriginal Law and Culture Centre
KAMSC	Kimberley Aboriginal Medical Services Council
KCDST	Kimberley Community Drug Service Team
KIWAC	Kullari Indigenous Women's Aboriginal Corporation
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAHSWP	National Aboriginal Health Strategy Working Party
NHMRC	National Health and Medical Research Council
NWMHS	Northwest Mental Health Service
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
TICHR	Telethon Institute for Child Health Research
WAACHS	Western Australian Aboriginal Child Health Survey
WAAHIEC	Western Australian Aboriginal Health Information and Ethics Committee

APPENDIX A

Memorandum of Understanding

Between

The Project Team

From
Curtin University of Technology, a body corporate established under the Curtin University of Technology Act 1966 as amended of Kent Street, Bentley, Western Australia, through its School of Psychology.

And

Kimberley Aboriginal Medical Services Council Inc.

For the research project:

'Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project'.

September, 2003

1. Preamble

This memorandum of understanding is to provide a basis for recognition of the roles and responsibilities and mutual cooperation between the Project Team, consisting of Melinda Andrews (PhD student and Project Coordinator), David Vicary, Clare Roberts, Brian Bishop, Jan Piek (Chief Investigators) and Kimberley Aboriginal Medical Service Council Inc (KAMSC).

1.1 In order to work in collaboration on the '*Promoting the Well-being of West Kimberley Aboriginal Children and Youth*' project, to achieve a common goal of further understanding and strengthening the social and emotional wellbeing of Aboriginal young people and their families living in remote West Kimberley communities.

2. Background Information

This project has been derived from research and projects involving Aboriginal people in Kimberley communities and towns, such as the Choose Life Report (KAMSC, 1999), Engagement and Intervention for Non-Aboriginal Therapists Working with Western Australian Aboriginal People (Vicary, 2002), as well as consultation with key West Kimberley based agencies and service providers, communities and local Aboriginal people.

Young Aboriginal people face many difficult issues such as racism, family violence, fewer work and schooling opportunities, the effects of traumatic experiences both past and present, to name a few (KAMSC, 1999). These events have been shown to result in social and emotional problems for young Aboriginal people, their families and communities. Some problems experienced by Aboriginal children and youth in the North-west and Kimberley, are boredom, low self-esteem, relationship breakdown, drug and alcohol misuse, anger, hopelessness (KAMSC, 1999; Hunter 1997), depression, anxiety and suicide (Hunter, 1991; Westerman, 2002). The Kimberley has been chosen as the key focus of this project due to the high rates of mental ill health and youth suicide reported amongst Kimberley Aboriginal people (Hillman et al., 2000, Hunter, 1991), as well as reported concerns about the lack of culturally appropriate strategies to manage these problems (e.g., National Aboriginal Health Strategy, 1993; Kimberley Regional Aboriginal Health Plan, 1999; Kimberley Regional Aboriginal Mental Health Plan, in press).

Some young Aboriginal people cope better than others, even though they have to deal with the same sorts of problems in life. For instance, not every young person who has experienced trauma has ongoing hopelessness, low self-esteem or mental health problems. It is important to know what it is about these young people that enable them to cope well with life and bounce back from adversity, as well as, understanding what risk factors lead other youngsters to succumb to these life stresses.

Therefore, a major aim of this project is to explore how young Aboriginal people and communities cope with the range of social and emotional issues affecting them. Most

importantly, the project aims to develop culturally appropriate intervention strategies, which focus on facilitating the development of coping skills and resilience in young Aboriginal people and their communities. As such, this project clearly focuses on skills facilitation and developing capacity within remote Aboriginal communities to deal with problems affecting Aboriginal people, at a local level.

3. Aims

Stage 1 Part A:

3.1 Identify and conceptualise the main social and emotional problems affecting young Aboriginal people in the West Kimberley.

3.2 Identify and explain the factors which place young Aboriginal people in the West Kimberley at risk of experiencing social and emotional problems.

3.3 Explore methods and practices used by individuals, families and communities, to cope with the range of social and emotional problems affecting young Aboriginal people in the West Kimberley.

3.4 Identify and explain social and emotional resilience in young Aboriginal people in the West Kimberley.

3.5 Identify and explain 'wellbeing' in young Aboriginal people in the West Kimberley.

Stage 1 Part B:

3.6 Explore local people's ideas about strategies and ways of implementing these strategies, which would be most appropriate to build resilience and promote the wellbeing of Aboriginal young people and their families in remote West Kimberley communities.

Stage 2:

3.7 Develop community-based intervention strategies to build resilience and promote the wellbeing of Aboriginal young people and their families living in two remote communities in the West Kimberley.

3.8 Culturally validate and pilot the intervention strategies in two remote West Kimberley communities.

4. Responsibilities of The Project Team

Throughout this project the Project Team agrees to –

4.1 Ensure the ongoing consultation and involvement of West Kimberley Aboriginal people in the development and implementation of the project and for their participation to be appropriately acknowledged.

4.2 Maintain that the project is reflective of both the collective and diverse experiences both past and present, of West Kimberley Aboriginal people and communities.

4.3 Ensure the delivery of practical benefits to communities involved in the project, through the development of community-based intervention strategies, which aim to build resilience and promote the wellbeing of Aboriginal young people and their families, as well as providing employment and training (e.g., workshops) to Aboriginal people in the West Kimberley.

4.4 Maintain that written informed consent be gained both at the community and individual participant level and meaningful consultation has taken place prior to ensure that people are well informed about their involvement in the project.

4.5 Ensure that written informed consent be gained from parents/carers when people under 18 years are to be involved as participants.

4.6 Maintain the confidentiality and anonymity of all participants, their families, agencies and communities, through secure storage of participant information (by the project coordinator for a period of up to 5 years); using no identifiable material in transcripts and feedback of results or reports; keeping identifiable material separate from tapes and transcripts; ensuring that the transcribers and other employees (where applicable) sign a 'confidentiality agreement'.

4.7 Provide both written and verbal feedback of results (i.e., general themes) to participants, agencies and communities involved in the project prior to the development of intervention strategies and allow for discussion and comment on these results.

4.8 Provide a summarised version of the final report derived from this project to participants. Provide copies of the full final report and report on the intervention strategies to KAMSC, Northwest Mental Health Service (NWMHS) in Broome, and participating community councils (or other nominated community party) for future accessibility of this information by Kimberley Aboriginal people and agencies.

4.9 Provide drafts of publication material to the project Steering Group (representative, KAMSC; manager, NWMHS or nominated persons in their absence) and members of the Project Advisory Group (i.e., PAG are Aboriginal service providers from Kimberley Community Drug Service

Team, Broome Regional Aboriginal Medical Service, Burdekin, Garnduwa) for comment and feedback.

4.10 Maintain that written reports, articles and other written material based on the final outcomes of this research will not be published without the formal agreement of KAMSC, as demonstrated by a signed letter from the Chairperson or Chief Executive Officer of KAMSC. KAMSC undertakes not to withhold agreement to publish unreasonably and to take all steps to respond quickly with feedback to drafts and with approval or clear reasons for non-approval of final documents intended for publication. If KAMSC does not respond within one month to documents sent for feedback, the Project Team undertakes to write to KAMSC and ask for a response urgently. If after a further four weeks following receipt of such a letter, KAMSC has not responded in writing then KAMSC will be deemed to have agreed to publication.

4.11 Melinda Andrews will provide drafts of her doctoral thesis to the Steering Group and PAG for comment and feedback. KAMSC is given the opportunity to review drafts and request modification of these drafts, to avoid disclosing information considered by KAMSC to be potentially detrimental to Aboriginal communities in the Kimberley, or if this is not done Curtin will take all steps to ensure that the thesis is examined in confidence and withheld from access to the public for a period of two years.

4.12 Provide a final marked spiral bound copy of Melinda Andrews' doctoral thesis to KAMSC and NWMHS.

4.13 The Project team agrees to maintain the following protocol for identifying and dealing with participants experiencing distress and those 'at risk' (e.g., suicide ideation, sexual abuse) as follows –

4.13.1 Identify referral options and consult with these agencies and service providers about the project, prior to data collection.

4.13.2 The interviewers (a qualified Psychologist with clinical psychology training and a Clinical Psychologist with 8 years experience in child protection issues) with the assistance of a nominated Aboriginal person (if necessary), will speak to the participant as soon as possible to investigate the nature and extent of the problem.

4.13.3 Advice will be given to the individual and family on appropriate immediate management of the problem and if necessary the individual/family member will be linked into the appropriate social and emotional wellbeing (SEWB)/mental health service provider connected with that community. Referral options and other intervention procedures will be explained in full to the individual and family. If the individual and family requests cultural intervention procedures, these will

be incorporated in the intervention as deemed appropriate by the individual and community (e.g., traditional healing).

4.13.4 In an urgent crisis matter, where a person is 'at risk' to themselves or others the interviewer(s) will undertake a crisis risk assessment and risk management to ensure the individual and/ or other's immediate safety, and link the individual/family into the appropriate SEWB/mental health service provider connected with that community, for ongoing counselling or support.

4.13.5 The interviewers will not be involved in providing clinical services to individuals, families or communities on an ongoing basis. However, support and monitoring can be provided by phone to assist the service provider who is dealing with the client(s).

5. Responsibilities of KAMSC

Throughout this project KAMSC agrees to –

5.1 Participate in the ongoing consultation and involvement of West Kimberley Aboriginal people in the development and implementation of the project through -

5.1.1 involvement in the Project Steering Group, by allowing for a nominated person to attend up to 10 meetings throughout 2003 and 2004, in order to discuss and provide recommendations and feedback to the project coordinator, on the cultural appropriateness and relevance of aims, objectives, interview questions, research processes and outcomes and general protocol for engaging and working with remote West Kimberley Aboriginal Communities (this may also be done via phone and email).

5.2 Store and distribute on request, final reports derived from this project to ensure future accessibility of this information to Kimberley Aboriginal people and agencies.

5.3 Provide comment and feedback on drafts of publication material (Please refer to clause 4.10).

5.4 KAMSC acknowledges that a Curtin enrolled student (Melinda Andrews) who is involved in this project, is required to produce certain assessment works for the requirements of her enrolled PhD course. KAMSC further acknowledges and agrees that nothing in this MOU shall prevent Melinda Andrews from providing any assessment work to Curtin's examiners for assessment, provided that KAMSC is given the opportunity to review the assessment works and to request modification of the assessment works to

avoid disclosing information considered by KAMSC to be potentially detrimental to Aboriginal communities in the Kimberley, or if this is not done Curtin will take all steps to ensure that the assessment works are examined in confidence and withheld from access to the public for a period of two years. KAMSC agrees to provide comment and feedback on drafts of Melinda Andrews' doctoral thesis, within a suitable timeframe, which allows for commenter reflection and respects the time constraints of PhD submission.

5.5 KAMSC agrees that under Curtin's Intellectual Property Policy, Melinda Andrews has copyright of new information contained in and developed from her thesis. Any resources or other products of this research will be available free of charge to organisations involved in this research and other local Aboriginal community controlled organisations and that the source be appropriately acknowledged.

5.6 Store and make available on request, a final marked spiral bound copy of Melinda Andrews' doctoral thesis for Kimberley people and agencies who may be interested in accessing it.

5.7 Assist in maintaining the protocol for identifying and dealing with participants experiencing distress and those 'at risk' (e.g., suicide ideation, sexual abuse) by notifying the interviewers of any participants known to be experiencing distress or 'at risk' and where appropriate assist in offering referral options.

6. Amendments to the MOU

Amendments to the MOU can be made subject to the written mutual consent of both parties which are signed by the duly authorised signatory of each party.

7. Termination

Either party may terminate this MOU upon issuing the other party with one month's written notice of that party's intention to terminate the MOU.

8. Signatories

Signed:_____ Date:_____
Yvette Roe
Chief Executive Officer

Kimberley Aboriginal Medical Services Council Inc.

Signed:_____ Date:_____
Dr Barney Glover
Director, Research and Development
Curtin University of Technology

APPENDIX B

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project.

Statement of Community Consent

I,_____as community elected representative of_____Community, agree for this community to be involved in the project *'Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth'* from 2003-2004, which in part forms Melinda Andrews doctoral research in Clinical Psychology through Curtin University of Technology.

I confirm that Council has been given information about the project and fieldwork to be done in this community and has been given the opportunity to have input into the nature and process of this fieldwork. I fully understand what is needed of this community when I agree for this community to take part in this study.

I know that the information given by community members will be kept strictly confidential and otherwise restricted to the project team (i.e., interviewers, supervisors, data entry person). I know that when not in use the information given by this community will be kept secure and private by Melinda Andrews (project coordinator).

I understand that community members involved in this project will be given written information about the results of this study and they will be able to take part in a discussion meeting to comment on these results. I accept that community members involved in the study will be given a summary of the final report at the end of the study and can access the full final report from their Community Council, Kimberley Aboriginal Medical Services Inc, or Northwest Mental Health Service in Broome. I understand that individuals, their family and/or agency and community, will not be identified in any way in the reports that come out of this study.

I understand that community members take part in this study freely and I know that they can leave the study at any time if I want to.

I have been given the chance to ask any questions about this community's involvement and these questions have been answered to my satisfaction.

Signed: _____ Witnessed: _____
Title:_____ Title:_____
Date:_____ Date:_____

APPENDIX C

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project.

INFORMATION SHEET

What is this project about?

This is a 3-year project funded by Healthway and Rotary. It hopes to find out how young Aboriginal people living in remote West Kimberley communities, deal with hard times they may face and what local people think are the best ways to promote the wellbeing of young Aboriginal people, their families and communities.

Who will benefit from this project?

The remote communities involved in this project will directly benefit by the development of activities that help build strengths and promote the social and emotional wellbeing of young Aboriginal people. West Kimberley based Aboriginal people will benefit by employment and training provided as part of this project.

Who will take part?

About 25 people in Broome will take part in the practice study starting June 2003. About 60 people from up to 3 West Kimberley communities will take part in the main study starting August 2003.

These people will be agency service providers, parents/carers of young Aboriginal people, and Aboriginal youth (aged 13-25). People who take part, do so at their own free will and can leave the study at any time if they want to.

What does it mean to be involved?

Stage 1:

Firstly, people will take part in a short interview (yarn) or small discussion group with either Melinda Andrews (project coordinator) or Mandy Juniper (project consultant). People will be asked about how Aboriginal kids cope with life's challenges, what makes them deal well and not so well with problems. Those involved can bring along another person to sit in on the interview if they wish. This person can help guide the interviewer on anything 'culture way' that may come up during the interview and to let the interviewer know how to deal with this in the best way for the person who is taking part.

Stage 2:

People will then be involved in discussion groups held in Broome, and remote West Kimberley communities, to help work out the best ways of helping young Aboriginal people deal with hard

times, as well as the best ways to carry out these activities in the remote communities involved in the project.

People involved in the project will then take part in a discussion group to comment on the general information given during stage 1 and 2. These groups will be held in Broome and One Arm Point in December 2003.

If anyone involved has any upsetting feelings during or after interviews/discussion groups, there will be plenty of time to talk about these feelings with the interviewer or let the interviewer know and she will refer on to someone who the person feels comfortable talking to.

Can I be sure my information is kept private?

Yes. The information you or your child gives will be restricted to the project team (i.e., interviewers, supervisors and data entry person) and will otherwise be kept strictly confidential. You, your family or your agency will not be identified in any way in the write up of information. When not in use, your information will be kept secure and private by Melinda Andrews (project coordinator).

Will I be able to see and comment on the final results?

Yes. All people involved will be given written information about the results and they will be able to take part in a discussion meeting, so they can comment on the results of this study. All participants will be given a summary version of the final report.
If anyone involved in the study would like to see the full final report after the project they will be able to get this report from Melinda Andrews (project coordinator), Kimberley Aboriginal Medical Services Council Inc., Northwest Mental Health Service in Broome, or from their community Council.

Has this project been passed by the Ethics board?

Yes. This project has been approved by Curtin University of Technology, Human Research Ethics Committee, The Western Australian Aboriginal Health Information and Ethics Committee and endorsed locally by Kimberley Aboriginal Medical Services Council Inc.

Who do I contact if I want to know more?

Please call Melinda Andrews (project coordinator) on (08) 9192 3420 or 0419 949 602, Email: m.andrews@curtin.edu.au or send a letter to PO Box 5684 Cable Beach WA 6726. You can also call Mandy Juniper (project consultant) on (08) 9193 6265, or Email: mandyjun@westnet.com.au.

If you want to talk to some one from our Perth Project Team from Curtin University please call Brian Bishop on (08) 9266 7181 or David Vicary on (08) 9222 2555.

We thank-you for taking part in this project!

APPENDIX D

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project.

Statement of Consent

I, _____agree to be interviewed by Melinda Andrews or Mandy Juniper, for the project 'Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth', for the purposes of Melinda Andrews doctoral research in Clinical Psychology through Curtin University of Technology.

I have been given an information sheet and have been told what is involved in this study. I fully understand what is needed of me when I take part in this study.

I understand and accept that the interview will be audio taped. I know that the information I give will be restricted to the project team (i.e., interviewers, supervisors, data entry person) and will otherwise be kept strictly confidential. I know that when not in use my information will be kept secure and private.

I understand that I will be given written information about the results of this study and I will be able to take part in a discussion meeting so I can comment on these results. I accept that I will be given a summary of the final report at the end of the study. I understand that myself, my family and/or agency will not be identified in any way in the reports that come out of this study.

I understand that I take part in this study freely and I know that I can leave the study at any time if I want to.

I have been given the chance to ask any questions about my involvement and these questions have been answered to my satisfaction.

I declare that I am over 18 years of age.

Signed: _____ Witnessed: _____
Date:_____ Date: _____

APPENDIX E

List of Agencies Involved in Consultation

- Kulunga Research Network at the Telethon Institute for Child Health Research
- Kimberley Aboriginal Medical Services Council (KAMSC)
- Derby Aboriginal Health Service (DAHS)
- Nindilingarri Cultural Health Service at Fitzroy Crossing
- Broome Regional Aboriginal Medical Service (BRAMS)
- Northwest Mental Health Service (NWMHS)
- Kimberley Community Drug Service Team (KCDST)
- Garnduwa Amboorny Wirnan Kimberley Sport and Recreation (Garnduwa)
- Burdekin Youth In Action (Burdekin)
- Department of Corrective Services (DoCS)
- Department for Community Development (DCD) and the Family Safety Project
- Broome Youth Drop-In-Centre
- Centacare Kimberley
- Broome Men's Outreach Service
- Marnja Jarndu Women's Refuge and Outreach
- Kimberley Regional Domestic Violence Coordinating Committee
- Kinway Counselling
- Kullari Indigenous Women's Aboriginal Corporation (KIWAC)
- Milliya Rumurra Alcohol and Drug Rehabilitation Centre and the Dampier Peninsula Alcohol and Drug Misuse Prevention Project
- Commonwealth Department for Health and Aged Care (CDHAC) and Family and Community Services (FACS) and the National Youth Suicide Prevention Strategy
- Kimberley Office for Children and Youth
- Aboriginal and Torres Strait Islander Commission (ATSIC) and Broome Indigenous Coordinating Centre (ICC)
- Commonwealth Rehabilitation Services (CRS)
- Kimberley Psychological Services
- Indigenous Psychological Services (IPS)
- Broome TAFE
- University of Notre Dame, Broome

APPENDIX F

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project.

Confidentiality Agreement
Project Assistant

Whilst undertaking my role as Project Assistant for the research project 'Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth',
I, _____ agree to respect the privacy and maintain confidentiality of all people involved in this project, at all times.

I agree to maintain the privacy of participants by not disclosing the identities of participants, their families, agencies and communities to people outside the Broome project team (i.e., Melinda Andrews and Mandy Juniper). I agree to maintain confidentiality of all the information given by participants for this project, by not speaking of this information to people outside the Broome project team.

I agree to keep all participant information secure and private when I am working with it, and to pass the information back to Melinda Andrews (Project Coordinator) when not in use, for secure storage.

I agree to use the information given by participants solely for the purposes outlined to me by Melinda Andrews (e.g., transcribing this information).

I understand that any breach of this agreement will result in termination of my contract with the project and Curtin University of Technology.

I understand the information outlined above and have been given an opportunity to clarify any questions I may have about this information.

Signed:_____ Witnessed:_____
Date:_____ Date:_____

APPENDIX G

Tabular Representations of Participant Demographics

Table G1. *Representation of Aboriginal Language Groups*

Language Groups	Location	
	Broome	One Arm Point
Karrajarri	2	-
Yawuru	2	-
Karrajarri &Yawuru	1	-
Yawuru & Jabir Jabir	1	-
Bard/Bardi	4	45
Bardi & Yawuru	1	-
Nyul Nyul	2	1
Bardi & Nyul Nyul	-	2
Bardi & Nginun	-	1
Mangala	-	1
Kija	3	-
Jaru	1	-
Gooniyandi	1	-
Wajarri Yamaji	-	1
Noongar	1	-
None identified	8	3
N/A	5	5
TOTAL	32	59

Table G2. *Aboriginal Languages Spoken by Participants*

Language Spoken	Broome	One Arm Point
Well	3	19
Some	9	29
None	4	3
N/A	13	8
Did not respond	2	0
TOTAL	32	59

Table G3. *Family Constellation and Number of People Living in the Home*

	Broome	One Arm Point
Family Constellation		
Nuclear	15	27
Blended	4	6
Extended	6	23
Sole Parent	1	0
Couple	2	0
Single	2	1
Shared House	1	1
Did not respond	1	1
TOTAL	32	59
Number of Occupants		
1-4	18	23
5-7	10	30
8-9	0	5
Did not respond	4	1
TOTAL	32	59

APPENDIX H

Study 1: Semi-structured Interview Schedule

Parent/Carer Interview Schedule

Introduction
Today we will be talking about how young Aboriginal people living in remote communities in the West Kimberley, deal with problems in life, what makes them deal well and not so well with the problems they may face. Also, we'll be talking about what families and communities do to help young people cope with problems.

Please let me know when you want a break. We can stop talking at any time. And remember, you don't have to talk about things you don't want to talk about.

(If Information Sheet and Consent Form haven't been done yet)
Before we start we'll go through a bit more information about the project and I have a form for you to sign to say you agree to take part in this interview (Refer to Information Sheet and Consent Form).

Answer any questions about the interview or project.

Continue to establish rapport

(Start Tape Here) Lead in Questions
E.g., What's it been like for you being a parent?….I bet it can be hard sometimes..

Interview Questions

PART 1: Risk and Resilience

1. What sort of social and emotional problems do young people in this community have to deal with? (Prompt: Hard times they have to deal with).

2. Can you think of a time when you knew a young person was dealing with something really hard..? What was the situation (Prompt: what age, gender of kid)**? How did they act? (Prompt: from what you saw or heard….what were they thinking to themselves? How were they feeling?**

Explore the problem and associated behaviours, thoughts, feelings

3. When a young person is going through a really hard time what things have you seen young people do to try and deal with their problems? (Prompt: What about the family ..what do they do to help? And the community? … the school, clinic, outside agencies etc do to help?)

Explore individual/family/community/agency coping

4. Some young people face big problems yet get over them pretty quick and get on with life. What is it about these kids that they deal ok with problems? (Prompt: What about things in the family, the community, culture, society?)

Explore protective factors

5. **Some young people take a lot longer to get over a problem and may even get worse** (Prompt: like get depressed or have suicidal thoughts). **What is it about these kids that they have trouble getting over their problems?** (Prompt: What about things in the family, the community, culture, society?)

Explore risk factors

6. Overall, what do you think are the 3 most important things that relate to the way young people deal with problems and go on to live a happy life? (Prompt: 3 things that make young people cope or not cope so well..e.g., supports, life events, how many, how recent).

Explore major contributing factors to coping

7. Some people overcome a lot of problems and get on with their life. What do you think makes young Aboriginal people this way (say someone who is 18-25)? What things about the young person would let you know they were someone who has dealt with hard times and gone on to live a happy life. (Prompt: A 'strong' person).

Explore definitions of social and emotional resilience

8. How would you describe 'wellbeing' for young Aboriginal people in this community? (Prompt: What it means for young Aboriginal people to be going 'ok', happy in life).

Explore definitions and characteristics of wellbeing

Anything Else to Add???

Early next year we will be holding meetings to talk about the best ways of building strengths in young people in this community and we hope you can come up with activities to run in One Arm Point next year.

THANK-YOU!!

APPENDIX I

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth

Study 2: Schedule of Questions for Groups

Forms for New Participants
Information Sheet (give and/or read & explain – do before group)
Consent Form (as above – do before group)
Demographics (as above – can do after group)

Forms for Group
Participant List (pass around or do yourself if you know info)
Focus Group Notes Sheet (do after group)
Progress Report (Give and/or read & explain –do after group or other time)

TEST OUT TAPE
Turn Tape on

Introduction
Thanks for coming along.

So far this year we've talked to people in Broome and One Arm Point about what sorts of problems young Aboriginal kids have, and what families and communities do to help kids who have problems. People have talked about lots of problems like – young kids having 'big shame', being bored, suicide, sexual abuse, using too much gunja and alcohol, family fighting etc. We'll talk with you about what information people have given us, at the end of the year, when we have sorted through it all.

In this group, we'll be talking about what community people and visiting agencies can do to help kids and their families deal with some of these problems. So, what we want to do here is for us to come up with as many ideas as we can about ways of helping young people and families, and the best ways to run these activities with your community.

Now for this group today, can we agree that any private things we talk about stays in the group?

Anyone got any questions?

Study 2: Questions for Groups

Qu. 1. What are some of the activities or services you know of for young people or families that are run in this community? What have been some of the problems with these activities/programs or services?

Qu. 2. What would have made them better?

Qu. 3. What would you like to see happen in your community to help young people and their families deal better with problems? (Prompt: what sorts of skills do you think young people, families, agencies need?)

Qu 4. Who would take part? Why these people? (Prompt: youth, parents, Elders, workers, outside agency workers).

Qu. 5. Who would be the best people/agency(s) to run the activity(s) in the community?

Qu. 6. Where would be the best place to run the activity(s)? (Prompt: school, community, outside community).

Qu. 7. When would you run the activity(s)? (Prompt: after school, mid yr)

APPENDIX J

Promoting the Wellbeing of West Kimberley Aboriginal Children and Youth: A Collaborative Community-based Project.

Parent/Carer

Demographics

Id #: _____

Age: _____

Gender: **Male** **Female**

Ethnicity: **Aboriginal** **Torres Strait Islander** **Non-Indigenous**

Place of birth: _____

Currently living: _____

Language group: _____**Speak this language:** Y N Some
Main language spoken at home: _____
Other languages spoken: _____

Level of education: _____
Type of education/training: _____

Job Title: CDEP (Name of program) _____ **Home duties**
Pension(type)_____
Other_____

Family Income: **<20,000** **20,001- 50,000** **>50,001**
(per year)

List all people living in the house, their relationship and ages (if known) **(include children in care). Example: partner, 34; son, 13; son 8; niece, 15.**
_____
_____
_____

Parenting (who does it and how much):_____

_____